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The Illinois Medical Journal

The Official Journal Of

The Illinois State Medical Society



VOLUME 103

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Vol. 103, No. 1 January, 1953

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THE 1953 ANNUAL DUES

An effort has been made in recent months, to inform the members of the Illinois State Medical Society why it was deemed advisable by the House of Delegates, to raise the annual dues for 1953. You will recall that for one hundred years the A.M.A. did not have annual dues, and payment of dues was only for the county and state medical societies. Then three years ago, the A.M.A. House of Delegates voted unanimously to have annual dues of $25.00 to be collected at the county or state level along with other dues. The annual dues for the Illinois State Medical Society have been much lower than those for other large state societies throughout the nation.

The financial plight of our fine medical schools has been under discussion for a number of years, and it is a well known fact that they cannot nearly pay the expenses of their operation from student income. We were informed recently that one of the larger medical schools had a deficit last year of more than nine million dollars. Everything used in our modern teaching of medicine has increased in price, and the dollar has been gradually depreciating during recent years. The American Medical Educational Foundation was organized to collect funds for the schools, and they have done a fine job, although to date, not nearly enough. The House of Delegates of the Illinois State Medical Society at its 1952 annual meeting and after much discussion, voted unanimously to increase the annual dues for 1953, $20.00 and all of this increase to go to the medical educational fund. If desired, members may designate their own alma mater to receive their donation.

The Medical Benevolence Fund has enough funds at this time to carry on its functions and the House of Delegates voted to place $2.00 from each membership in the fund, instead of $5.00 per year as has been done in recent years. With donations from the Woman's Auxiliary and from other sources, it is believed that the present surplus can be maintained, the additional amounts donated will be sufficient to carry on the fine work which has been done over a period of some 13 years. We have compared the dues of members of the Illinois State Medical Society with other professional organizations, many unions, and other groups and with the present increase in dues, the members of this Society pay far less than members of many of these societies or organizations. For 1953, in addition to the county society dues, the secretary of county medical societies will collect $40.00 for the State Society, $20.00 of which automatically goes to the Medical Educational fund, and $2.00 into the Medical Benevolence fund. Then the A.M.A. dues of $25.00 is also to be collected at the county

level, this going from the State Society to the A.M.A. No dues should be sent directly to the Medical Educational Fund or to the American Medical Association, as these sums must be sent to the office of the State Society Secretary. When checks are sent to the A.M.A., they must be returned to the State Society where the necessary entries must be made before the dues are sent to the A.M.A.

The Secretary of either the State Medical Society or the county societies can give information to members on this subject, as can likewise, the Councilors for the respective Councilor Districts over the state of Illinois.

Annual dues should be paid early in the year, thus making the work of the secretaries as well as the accounting department of the American Medical Association much easier. Likewise the medical schools need financial aid, and all funds received for them will be speedily sent to the Medical Educational Fund.

PHYSICIANS AND MARCH OF DIMES

Probably no greater example of cooperative effort has been demonstrated than by the success of the National Foundation for Infantile Paralysis. The recent reported results of use of Red Cross Gamma Globulin as a prophylactic agent for poliomyelitis is the fine example of cooperative spirit.

The public donated their blood to Red Cross and contributed liberally in the "March of Dimes." The thousands of volunteer workers helped make the entire program a success. In addition, they displayed their confidence in the workings of organized medicine in allowing their children to be subjects of these tests, knowing well some would receive Gamma Globulin and others a harmless substitute.

Physicians, health officers, and nurses cooperated to the fullest extent in the advice given patients, and of their time in making the study a success. The National Foundation expended a million dollars in proving one of the first safe and reliable methods in reducing the susceptibility and severity of the dreaded disease in an epidemic area. Much remains to be accomplished before the goal of the National Foundation is realized.

Physicians throughout the state are urged to take an active interest in the local chapter. Their cooperation and advice is essential to insure patient care. Polio, being a medical problem requires endorsement and the cooperation of medical men.

The medical profession, long known for its exhibitions of charity should continue its endorsement of the program, and encourage contributions to the "March of Dimes" which makes the research work, training of skilled help, by means of fellowships etc. Last but not least, patient care, which accounts for 74 per cent of total expenditure of the "March of Dimes" funds.

OSTEOPOROSIS

Senile osteoporosis leads to considerable pain and disability in older persons. Women are afflicted more often than men and the majority of victims are over 55 years old. Excellent results are being reported with testosterone.

Osteoporosis produces decreased bone density and results from processes that interfere with matrix formation. Causative factors include disuse, lack of stress and strain, protein deficiency, and steroid imbalance. There is mounting evidence to support the theory, however, that the chief origin of the senile type is underfunctioning of the gonadal hormone producing glands. This would explain why the condition is observed in postmenopausal women up to age 65. When the disorder occurs after this age, it is the senile variety although the two types are barely indistinguishable. On the other hand, the theory does not account for the relative infrequency of the abnormality in men, even those beyond 70 years of age. A relationship exists, however, between osteoporosis and longstanding eunuchoid males 10 or more years past puberty. In these males, the condition is indistinguishable from the senile variety.

The hormone theory is given another boost by the observation that the excretion of calcium and phosphorus in the urine is decreased when estrogens and testosterone are administered. The effects are noted within six days and reach a peak within a month. The response persists for 60 days after the drug is stopped. These findings explain the good results when testosterone is given to patients with osteoporosis.

(*Continued on page* 5)

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OSTEOPOROSIS (Continued)

Schoene[1] reported his results of four years' observation on 30 cases of senile osteoporosis in which testosterone was given intramuscularly, 25 mg., three times weekly for four weeks, then twice a week for four weeks, and finally weekly for four weeks. This was followed by a four week vacation from therapy. Pain disappeared within three weeks and there was a return of the sense of well being. Treatments lasting longer than six months rarely were needed.

Hallahan[2] was able to relieve symptoms in two cases with large injections of vitamin B^{12}. One patient had two recurrences, when the drug was stopped for two weeks and again, after a month. This author was unable to explain why the vitamin was effective.

Advanced cases of osteoporosis often require orthopedic supports for backache and deformities. To conserve the calcium content of the body the diet should exclude fats and cereals which inhibit calcium absorption. Vitamins C and D also are recommended.

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2. Hallahan, J. D., SYMPTOMATIC RELIEF OF OSTEOARTHRITIS AND OSTEOPOROSIS WITH VITAMIN B12. PRELIMINARY REPORT. Am. Practitioner & Digest of Treatment, 3:27 (Jan.) 1952.

DIABETES AND TUBERCULOSIS

For many years there has been a tradition that diabetes mellitus predisposes to tuberculosis, particularly pulmonary tuberculosis. There have been figures however which indicated that this assumption was perhaps fallacious. Wilder and Sprague* for example noted that the records of 3793 consecutive patients with diabetes at the Mayo Clinic, most of them checked by chest x rays, showed active tuberculosis in only 37, less than one per cent. The subject has recently been reviewed by Ferrara† who points out that some authorities claim that the incidence of tuberculosis in diabetics is three times as high as it is in the general population. If this is true no one has formulated a satisfactory explanation of the phenomenon. But, as William Gull once said "Savages explain, science investigates". Ferrara's figures, which are based on the records of the Uncas-on-Thames Tuberculosis Hospital, show the opposite situation to those of Wilder and Sprague, namely not the percentage of diabetics who show evidence of pulmonary tuberculosis, but the percentage of patients with pulmonary tuberculosis who show evidence of dia-

*Musser's Internal Medicine, 4th edition, p. 1201.

†New England Jour. Med. Jan. 10th, 1952.

betes. Of 3,178 patients admitted to the hospital for tuberculosis 68 or 2.1 per cent had associated diabetes mellitus. Inasmuch as 7 per cent of ordinary life insurance risks died of all forms of tuberculosis in 1951* neither the Mayo Clinic nor the life insurance figures seem to support the view that tuberculosis is unusually prevalent in diabetics.

However, Ferrara's statistics do show some important facts about tuberculosis in diabetics which should be carefully noted. In this day of new drugs for the treatment of tuberculosis it is important to know that the existence of diabetes in tuberculous patients has so far not been demonstrated to interfere with any form of antituberculous therapy. It is noted too that no significant relation was established between the degree of control of the diabetes and the course of the tuberculous infection. The fact that over two-thirds of Ferrara's series of patients with both diseases were over 40 years of age suggests the possibility that diabetes merely tends to activate latent tuberculosis, for while diabetes may occur at any age it is more prevalent in the elderly who are more likely to have inactive lung lesions. This indicates that age should not limit the obviously necessary lung x-rays which should be made periodically in all diabetics. The study also shows that in the great majority of patients with diabetes and tuberculosis the latter disease is rarely minimal but usually moderately or well-advanced. Finally, perhaps the most significant fact elicited by Ferrara's study is that in patients with concurrent diabetes and tuberculosis the prognosis of the latter disease is definitely graver than it is in the non-diabetic patient. Consequently x-ray examinations of lungs of tuberculous diabetics are indicated at least every six months and even more frequently if there are symptoms or signs suggesting the desirability of this. Needless to say all patients with a positive diagnosis of diabetes mellitus should have an x-ray of their lungs and all patients in whom a diagnosis of tuberculosis is made should have an examination of a 24 hour specimen of urine for sugar and, if indicated, a blood-sugar determination.

G.B.

*Life Insurance Fact Book, 1952, p.81.

"WAIT 'TILL MORNING!"

A plea for night and holiday service by hospital laboratories.

Dr. Frederick Stenn

Why is life less valuable on Sundays, holidays, evenings and nights than on week days between the hours of 8 AM and 5 PM? Who will say how many die needlessly on July 4th, Washington's Birthday, Labor Day, Christmas, New Years Day and the evenings preceeding them? What numbers reach their graves when they are so unfortunate to enter the hospital because of injury or disease at night time? The figures must be impressive.

If any department of the hospital is responsible for these casualties of medical neglect, that department is the clinical and x-ray laboratory, the doors of which are, for practical purpose, shut against the physician at 5 PM and on holidays.

Particularly shameful is this situation in our smaller hospitals, where the technicians on call usually live some distance away. The physician is reluctant in calling upon them for service. Only too often the technicians insist upon waiting until morning or until the holiday is over. But sickness and accident are not confined to the time when the sun shows above the horizon; sickness and accident do not respect the convenience of a hospital.

The assiduous physician, hard pressed by the labors of the day, struggles with his ailing one throughout the night. Is there a fracture? Has pneumonia developed or is it a pulmonary infarct? Is it an acute coronary thrombosis? May the coma be due to hypopotassemia? What is the blood sugar and CO_2 combining power? What are the chemical changes in the spinal fluid? Is there free gas in the abdominal cavity? Is the white blood count high? Does the patient continue to bleed within his intestine? These, and a score of other pertinent questions answered only in the x-ray and clinical laboratory, jar him with the importance of an immediate answer.

These questions must be answered promptly. Waiting may be a great virtue in medicine but in this instance, waiting is bidding welcome to an armed enemy. The gossamer of life is swept away only to quickly to wait. The Doctor tries

to do some of the laboratory work himself and finds this, and the assistance of his intern, insufficient.

"He trespasses against his duty" Edmund Burke wrote, "who sleeps upon his watch". The laboratory can no more be closed than the operating room. The technicians have no greater right to their repose than the anaesthetists. Continuous service is mandatory regardless of the sun's position in the heavens and regardless of the sacred days set aside for prayer or atonement or for celebration. The patient has a right to insist upon proper and efficient service irrespective of time. It is the technicians bounden function. It is the hospitals imperative responsibility. It is the doctors moral obligation to see that it is done!

CHICAGO!

Chicago — What have you got?
Not the light-hearted gayety of Paris?
Not the solemn and sober dignity of London?
Not the splendor and awesome ruins of Rome?
Not the financial cunning and wizzardry of New York?

Chicago, what *have* you got Only vision and tolerance as broad as the plains which surround you! Only imagination, initiative and drive so terrific that all other cities all over the world from their Dwarfism envy your Stature.

Chicago — you were spawned in the middle of the Indian Country. You grew up lustily, fighting with one hand, building with the other, building and swearing and working and laughing yourself into maturity, — always the same, your natural self, no pretense, no poise, no fear, no inhibitions — offspring of your Indian surroundings. Yet presently feeding and directing the destinies of the World!

Chicago — What have you got? Everything.

Robert S. Berghoff, M.D.

THE BENEVOLENCE FUND

Realizing that in our State there were doctors and their families, or widows of doctors, who, through no fault of their own, were in dire need of financial assistance, a Benevolence Fund was established in 1940. The management and the administration of the Fund rests upon a committee chosen by the House of Delegates. The maintenance is shared by the State Medical Society and the Woman's Auxiliary to that Society.

It is interesting to note here that in February, 1938, the State Auxiliary under the leadership of Mrs. Herbert B. Henkle, asked permission of the Council of the Illinois State Medical Society to establish this Fund, but plans had already been made for its operation, subject to House of Delegates approval.

No one of us expects to make use of this Fund. Neither did the sixty or more beneficiaries who have used it, nor the thirty (33) who are receiving help currently. A long debilitating disease or the infirmities of age, a disappointing retirement investment, living beyond normal life expectancy, inadequate reserve funds — all may conspire to upset anyone's planned financial security.

For those who are not versed with the scope of the Fund, a brief review is in order.

1. Beneficiaries: Needy doctors or their widows. Since its inception about 15% of the recipients have been doctors, the remainder their widows.

2. Maximum Benefits: Up to $50.00 per month. More is allowed in some cases where the administrators deem it necessary, subject to Council authorization.

3. Administrators: A committee elected by the House of Delegates of the State Medical Society. This committee serves without remuneration.

4. Administration: Any member of the Medical Society or its Auxiliary may report to the committee, the name of a doctor or his (her) widow (widower) stating that assistance is needed. Usually this is done by a local physician familiar with the family. The case is tactfully investigated by the Committee. An application form is filled out. All reports are confidential. The Secretary of the State Medical Society — Dr. Harold M. Camp, Monmouth, Illinois, serves on this Committee.

5. Amount in the Fund: At present, the checking account of the Fund has about $57,000.00, and there are $100,000.00 in bonds. Approximately $15,000.00 per year is being spent, now, on a pay-as-we-go basis.

6. Source of Moneys: Over the years, various amounts have been raised by the members of the Medical Society and its Auxiliary. At present, two dollars of the dues paid by each member of the Medical Society are allocated to the Fund. The maintenance of the Fund is one of the chief objectives of the Woman's Auxiliary. To date,

its members have contributed close to $30,000.00 Last year: $6,359.00; this year, it is hoped $10,000.00.

7. Memorial Gifts: Recently, upon the death of several Auxiliary members, their relatives and friends have sent contributions to the Fund instead of flowers to the family. Therefore, the Board of Directors of the Auxiliary voted to established within the Benevolence Fund, a *Memorial Fund* in the name of any member for whom twenty-five or more dollars were given. The first three memorials were for Mrs. Herbert B. Henkle, Mrs. Harry J. Dooley and Mrs. Solomon Jones — all loyal members.

These gifts are equally fitting in memory of physicians or others. All such contributions are promptly acknowledged and suitable notification sent to the family of the deceased. These contributions augment the income of the Fund. Many donors receive a deep satisfaction in giving to a *useful* and *living memorial.*

8. Honor Gifts: Contributions may also be given to honor men or women for outstanding achievements or service to the Society or profession.

The Benevolence Fund is a growing, going concern which meets a real need. Illinois is one of the few forward looking states to have such a Fund. To quote Dr. Harold Camp, it often "means the difference between enough and not enough"[1] for a doctor or his widow. It is a "cohesive force within organized medicine during this time of stress. It is a non-governmental cushion against disaster."[2]

There is an abiding sense of joy in knowing that as a team a doctor and his wife cheerfully have given — and will continue to give — to the Benevolence Fund. It is a Fund which helps soften the shock of financial worry for a team like us — or perhaps only one member of it.

By Mrs. George W. Koivun,
Benevolence Fund Chairman
for the Woman's Auxiliary
to the Illinois State Medical
Society.

(1) The Benevolence Fund, Its First Decade.
(2) by Harold M. Camp, M.D., Abst. of address before the Woman's Auxiliary of the Chicago Medical Society, Chicago 2/14/50.

IQ IN CEREBRAL PALSY

Dr. Winthrop Phelps has estimated that 30 per cent of the cerebral palsied are mentally defective, as a direct result of the brain damage, and that the remaining 70 per cent are normal "in the sense that these individuals show the normal spread of the population seen at large." This estimate has been widely quoted and almost as widely misunderstood. It frequently has been interpreted to mean that 70 per cent of the cerebral palsied have normal or superior intelligence. If intelligence is normally distributed among 70 per cent of the cerebral palsied population, one would expect an additional 2 per cent of the total group to be mentally defective, or 32 per cent in all; approximately 15 per cent would be expected to fall into the dull range from 70-89; while approximately 53 per cent would be expected to have average intelligence or better. *Ann Heilman, A New Interpretation Of Research Studies. The Crippled Child, Aug. 1952.*

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Archives in the Catacombs

Walter C. Bornemeier, M.D.

The medical profession and allied professions are always on the alert for ways and means to reduce the cost of medical care without, of course, reducing its quality. The price per patient for the average office or home visit is not much higher than it was twenty years ago. The doctor's income, in the main, has risen because of the possibility of seeing many more people than was possible in the days of pneumonia, diphtheria, scarlet fever, muddy roads and home deliveries. Therefore economies in physicians' charges are difficult or impossible to effect, so we must look elsewhere if any lessened cost is to be attained. The greatest increase in the portion of the medical care dollar has been taken by the hospital. Our friends in the labor movements admit freely that *labor* in hospitals is responsible for much of this increase. They are not interested in economies at the expense of labor. *Drugs* may be higher in price, but they are for the most part so effective in comparison to twenty years ago that they could cost twice as much and still be economical, judged by their ability to reduce hospital stay.

Food prices have increased and the employment of skillful dietitians adds to the cost. The benefits, however, exceed the disadvantages so it would be difficult to effect a reduction here.

Nurses, anesthetists, laboratory technicians, residents and interns are certainly not overpaid, and a few of them probably could use more money. Where then in a hospital can costs be cut? The business office that handles bills and all the necessary reports for the revenue department is getting bigger right along, but economies there mean trouble or loss of income. The purchasing department should be earning its keep. The Superintendent of Nurses smiles and says good morning — if she did nothing else all day, she could stay. So far we haven't saved a nickel.

We go into the record room. Four moderately well paid people are busy — filing, cross-filing, cataloguing chart after chart. It requires the full time of one clerk to sort out the incomplete or unsigned pages and file them so the doctor or resident guilty of negligence can have access to them when he appears, either voluntarily or when threatened with loss of hospital privileges. We find in the next room a tremendous project of microfilming of records. We pick up a record and find that the resident who took care of Job hasn't a progress note the day after the boils were

lanced. This record must be kept in a separate file until completed.

We asked two questions: (1) Why all the extensive filing of all records, the cross indexing by diseases and (2) How much does this add to the cost per patient. The answer to these questions is about the only thing not recorded in the record room.

Quick calculation reveals that the salaries of the people working in the record room for a hospital with 8,000 patients a year is about $12,000. That figures $1.50 per person or $750,000 for the half million patients in general hospitals each year in Illinois. How much does it cost to produce the record? It probably takes three times as long to produce the record as it does to file it, maybe it takes ten times as long. Using the lower figure, because we wouldn't, of course, eliminate the essentials of the record, we could save another $4.50 per patient or $2,250,000. So far that's three million annually for Illinois.

What does it cost to store such extensive records, or microfilm and store them? No one knows, but storage is apparently more costly than microfilming and microfilming costs plenty, a conservative estimate is $500 for each year of record.

Now we must go back to one of the original questions. Why keep such extensive records? I know it's "required," but we still may ask why. The answer obviously must be (1) to protect the patient; (2) to protect the hospital; (3) to protect the doctor; (4) to provide material for postgraduate medical education. Certainly the average patient could leave the hospital and satisfy points 1, 2 and 3 with essential information on a four by six card, filed alphabetically. Apparently then the extensive and costly portion of this effort is that used to satisfy point 4.

Now that we have some sort of an answer to the why and how much of keeping records, let's ask one more question. Is it the function of the hospital to provide a source of postgraduate information and should this be a legitimate medical care cost of the hospitalized patient? Surely some provision must be made for source material. Apparently most of it, at present, is *buried forever* at a cost of three million dollars plus storage each year for the state of Illinois. Certainly a good cross-section of information could be obtained for a fraction of the present cost by designating about six centers, one with each medical school and one at Cook County Hospital. Let them turn over their records, after first making a short abstract to provide protection for patient, doctor and hospital, to a central agency which could then cross index and file source material. The cost of this should be charged to postgraduate medical education.

Thus all other general hospitals would be relieved from extensive recording and filing of all except that information necessary to the immediate care of the patient. The doctor and nurse of course make and keep an accurate account of the patient's illness. This could be abstracted and filed very simply to provide a permanent record. All hospital charts would then be discarded except those where litigation seems likely.

Thus, from the standpoint of the patient, a very satisfactory record could be produced and stored at less cost. Certainly the care of the sick rather than the production of the record should be the primary duty of the physician and nurse, and data intended primarily for education should not be produced and then buried forever at the expense of the hospitalized patient.

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR FEBRUARY

Twenty clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The February clinics are:

February 4 — Hinsdale, Hinsdale Sanitarium

February 5 — Litchfield, St. Francis Hospital

February 10 — East St. Louis, Christian Welfare Hospital

February 10 — Peoria, St. Francis Hospital

February 10 — Vandalia, American Legion Home

February 11 — Elgin, Sherman Hospital

February 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

February 12 — Springfield, St. John's Hospital

February 12 — Tuscola, Moose Hall

February 13 — Chicago Heights (Rheumatic Fever), St. James Hospital

February 17 — Jacksonville, Passavant Hospital

February 18 — Chicago Heights, St. James Hospital

February 19 — Anna, New City Hospital

February 19 — Rockford, St. Anthony's Hospital

February 24 — Effingham (Rheumatic Fever), Douglas Township Building

February 24 — Peoria, St. Francis Hospital

February 25 — Carrollton, Grade School

February 25 — Springfield (Cerebral Palsy), Memorial Hospital

February 26 — Bloomington, St. Joseph's Hospital

February 27 — Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local

chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

"HEART DISEASE IN CHILDREN"

The American Heart Association and its affiliated Heart Associations throughout the country have begun distribution of a new booklet, "Heart Disease in Children."

The booklet is intended for parents, teachers, and all others concerned with the problems of child health and child care. It is recommended to physicians to use with parents of patients.

This booklet presents an up-to-date summary of the information now available on the prevention and treatment of rheumatic fever, the treatment of rheumatic heart disease, and the correction of congenital heart defects.

The booklet may be obtained from Illinois Heart Association, 526 South Seventh Street, Springfield, or from any of the county chapters of the state association. Requests from Cook, DuPage and southern half of Lake County should be directed to the Chicago Heart Association, 69 West Washington Street, Chicago.

I.M.A. CERTIFICATES

I have a piece of news which might be of interest for your next issue of Illinois Medical Journal. Being a member of the Industrial Medical Association (formerly the American Assn. of Industrial Physicians and Surg.), I contacted Dr. Edward C. Holmblad of Chicago, managing director of I.M.A. and submitted a suggestion that all active members of this organization be issued certificates of membership suitable for framing.

I have a letter before me from Dr. Holmblad informing me that my suggestion was presented to the Executive Committee and Board of Directors, and on October 19th the Board of Directors voted to supply such certificates to the active members of the Association. The certificates are now being made up and as soon as the format is approved by the Executive Committee they will be ordered. It is planned to send these certificates to members at the same time as the 1953 membership cards are mailed. I understand that it will be a very neat certificate suitable for framing. The above action will affect members in all states in U.S., Hawaii, Canada, Argentina, Brazil, and Mexico.

Many of our I.M.A members practice in Illinois and I am certain that they will be pleased to learn of our efforts in helping to obtain these certificates.

Jacob Chalfin, M.D.

JC/ipc

OBSTETRICIANS NAME CARTER PRESIDENT-ELECT; INSTALL KIMBROUGH PRESIDENT

Chicago, Dec. 16 — Bayard Carter, M.D., Durham, No. Car., was chosen president-elect of the American Academy of Obstetrics and Gynecology today during its three-day session here. He will take office next December in Cincinnati.

Robert A. Kimbrough, Jr., M.D., Philadelphia, Pa., who was president-elect last year, was installed as the new president.

Carter and other officers who will work with Kimbrough were elected at the business session this morning. The new secretary will be C. Paul Hodgkinson, M.D., Detroit, Mich.; assistant secretary will be Charles D. Kimball, M.D., Seattle; and the new second vice-president will be Joe Vincent Meigs, M.D., Boston.

Other officers re-elected were Howard Stearns, M.D., Portland, Ore., as first vice-president; and Herbert E. Schmitz, M.D., Chicago as treasurer.

Five district officers also were elected: John B. Montgomery, M.D., Philadelphia, and John I. Brewer, M.D., Chicago, as District Chairmen; and vice-chairmen Duncan E. Reid, M.D., Boston; Frank R. Lock, M.D., Winston-Salem, N.C.; and Willis E. Brown, M.D., Little Rock, Ark.

ELECTROCARDIOGRAPHIC INTERPRETATION

A course in Electrocardiographic Interpretation for *graduate physicians* will be given at the Michael Reese Hospital by Louis N. Katz, M.D., (Director of the Cardiovascular Department, Medical Research Institute) and associates. The class will meet each Wednesday from 7:00 to 9:00 PM for twelve weeks, beginning February 11.

Further information and a copy of the lecture schedule may be obtained upon application to Mrs. Rivian H. Lewin, Administrative Secretary, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

CHICAGO SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

Meeting of the Chicago Society of PM&R.
Date: January 28, 1953
6:15 P.M. Dinner — American Medical Assn. Bldg., 5th floor. 535 N. Dearborn St., Chicago 10.
Business Meeting immediately following the dinner.
SCIENTIFIC SESSION 8:00 P.M.
Place: American Medical Assn. Bldg., 9th floor Auditorium 535 N. Dearborn St., Chicago 10.
TOPICS: "The Council on Physical Medicine and Rehabilitation" by Dr. Ralph DeForest, Sec'y., Council PM&R.
"Demonstration of Some Physical Principles Used in Medical Apparatus"
by Mr. Howard Carter, Director Bio-Physical Investigation, Council PM&R.
"The Physical Laboratory of the Council of PM&R" by Dr. Frederick Jung, Director, Physical Laboratory.

Joseph Koczur, M.D.
Chairman, Committee on Education and Publicity

THE COOK COUNTY HOSPITAL DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Weekly
PATHOLOGICAL CONFERENCE
Every Wednesday — 11:00 AM County Morgue Amphitheater

An interesting case with presentation of pathological material at each session. Physicians may procure information by writing or calling the Medical Director.

CARCINOMA AND RECTAL POLYPS

Twenty-seven patients having carcinoma in rectal polyp have been followed for 2 to 10 years. All patients were treated by local incision, coagulation, or radon seed implantation, or by combinations with the latter. Sixteen lesions proved to be noninvasive carcinoma and 11 were invasive. The invasive group did not have radical surgery because of advanced age or infirmity. The incidence of carcinoma arising in polyp was found to be most frequent in the sixth and seventh decade of life, with the average age being 60.2 years. It is significant that no person in this series has died of recurrence or metastasis from the original tumor and that the deaths have been due to another primary lesion located above the rectum, other malignancies, or to unrelated conditions. Of the 27 reported cases, 2 have succumbed to undetected primary carcinomas of the colon above, while 2 others have recently returned for the removal of carcinomas located in the sigmoid colon. *Rupert B. Turnbull, Jr. and Edwin R. Fisher, Carcinoma in Rectal Polyp; Follow-Up Observations On 27 patients. Postgrad. Med., Oct. 1952.*

ORIGINAL ARTICLES



Modern Trends in the Surgical Management of Malignant Lesions of the Stomach and Colon

Claude J. Hunt, M.D.
Kansas City, Missouri

I wish to present here some controversial concepts of potential malignant and malignant lesions of the stomach and to discuss the modern trends in the surgical management of malignant lesions of both the stomach and colon. I shall present a personal approach to various aspects of the surgery of both of these structures.

Gastric Ulcer.—The treatment of gastric ulcer is a controversial subject. Since there is no positive way to determine the true nature of a gastric ulcerative lesion we believe that all of these ulcers should be considered malignant until proven otherwise.

The character of the lesion can not be determined by medical measures alone, as many early malignant ulcerative lesions will respond for a period of time to medical management. This probably is related to the recession of the infection and the inflammatory reaction that is often associated with early ulcerated malignancy.

This acute reaction may result from the corrosive action of the free acid that is so often present. Medical treatment neutralizes the acidity and a brief response is experienced.

Grimes and Bell[1] report that free gastric acid is present in these ulcerative malignant lesions in about 75 percent of cases and conversely free acid may be absent in 20-25 percent of the benign ulcerative lesions. Therefore, the absence or presence of free gastric acid is of little value in making a differential diagnosis.

The x-ray diagnosis may be unreliable as to the true nature of the lesion.

The diameter of the ulcer by x-ray studies offers no positive indication as to the nature of

Oration in Surgery. Presented at 112th Annual Meeting Illinois State Medical Society, Chicago, May 15, 1952.

the lesion. Grimes and Bell[1] report 17 of 24 malignant ulcers, or 71 percent, had a diameter of 3.0 cm or less, while 74 of 99 benign ulcers, or 75 percent, were 3.0 cm or less.

We believe that all ulcerative lesions of the stomach are potentially surgical and at most, only a very brief trial by medical management should be practiced.

If then there is a favorable response, frequent radiological observation should be made to evaluate the result. The incidence of diagnostic error is fully 10 percent while the operative mortality is 1 percent or less. There are few complications and a minimal morbidity following the resection of a gastric ulcer, therefore, we believe great responsibility rests upon the physician who elects medical rather than surgical management for the patient. Unfortunately, many may respond satisfactorily for a time, only to find in 3 to 6 months that the possibility of a cure has passed. It can not be overlooked that ulcer obliteration may be by proliferation of malignant cells and not by fibrous tissue. Ulcers may heal with microscopic foci of malignant cells enclosed within. The x-ray does not differentiate the type of healing that occurs.

Gastric Cancer.—The survival rate of gastric cancer after resection has improved little in recent years. The symptoms are vague, the patient presents himself late for diagnosis and the physician too often has a defeatest attitude toward operative interference. A similar attitude is unusual in other forms of disease even though the prognosis is no more promising.

According to Pack and McNeer[2] these malignant lesions are surgically removable in only about 35 or 40 percent, despite the fact that improved surgical techniques permit removal of lesions that were formerly considered unresectable.

The extension of the scope of surgery often includes resecting segments of the colon, mesocolon and large portions of the pancreas. Such procedures until recently were considered impossible. It is gratifying in many instances to observe extensions of life following these extensive procedures. We have on several occasions extended the scope of resection to include one or more of these structures and have seen results up to 5 years or more in a few instances. Certainly this is a procedure of merit when contrasted with futile and frustrated results from palliative measures.

Many surgical leaders[3] now advocate total gastrectomy for all resectable malignant lesions of the stomach, regardless of their location. This radical procedure is directed at removing more gland bearing tissue and is now being performed with a progressively reduced mortality rate. Mortality rates are determined largely by the technical skill and the surgical judgment of the surgeon.

The mortality of total gastrectomy would be greatly reduced from its present rate if performed for those lesions in the distal part of the stomach. This may in some instances be the factor in the reported reduced mortality for total gastrectomy.

There are many undesirable postoperative features that are associated with total gastrectomy. These are frequently related to malnutrition, inanition, secondary anemia and reflux esophagitis. These symptoms may be so pronounced that they may be considered a serious objection to total gastrectomy.

It is yet to be proven that total gastrectomy will materially increase the five year survival rate. When one considers the operative mortality and the post operative morbidity, the routing procedure may be a high price to pay for the questionable increase in life extension of the patient.

For lesions low in the stomach without glandular extension along the gastrohepatic omentum a partial gastrectomy is probably the procedure of choice.

If the gastrohepatic omentum or the celiac glands are involved, a total gastrectomy will not result in a cure but may afford palliative relief for an indefinite time.

Total gastrectomy is indicated for the linitis plastica type of carcinoma and for lesions in the upper segment of the stomach.

Total gastrectomy is best reserved for those lesions in which it appears—that is the only way in which all the visible disease can be removed.

Two factors are paramount to consider. The increased number of cured patients and a morbidity compatable with a comfortable life.

Surgical Procedures.—The standard type of esophago-jejunostomy with entero entero-anastomosis does not afford a large capacity for food

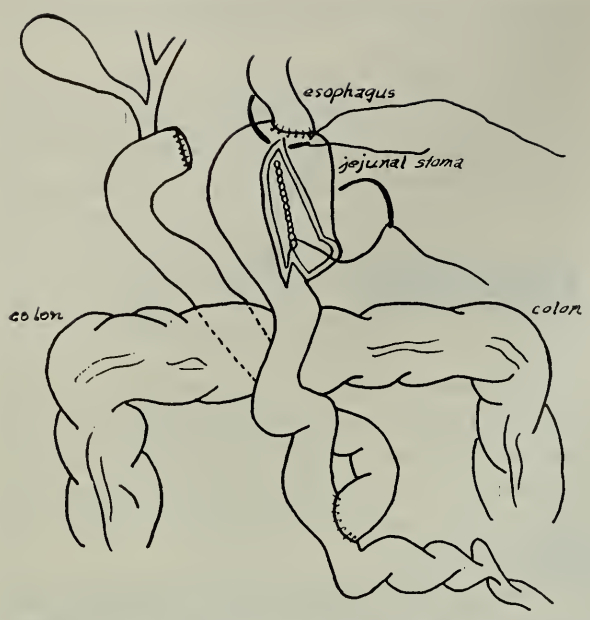


Figure 1. The jejunum has been divided about 12 inches distal to ligament of Treitz and a pouch is being constructed by joining the sides of a loop in the distal limb which has been anastomosed to the esophagus. The proximal end of the divided jejunum has been anastomosed to the side of the distal limb in a Roux-en-Y manner.

intake and does not entirely divert the duodenal contents through the stoma between the proximal and distal limbs of the jejunum. A reflux esophagitis frequently results, which causes discomfort and may promote stenosis of the esophago-jejunal anastomosis.

Consequently several attempts have been made to overcome the undesirable features of total gastrectomy.

Efforts have been directed at diverting the duodenal contents by a Roux-y procedure to prevent reflux esophagitis.

Various segments of the intestinal tract have been transplanted to substitute for the removed stomach. The intent has been to maintain the normal flow of food contents by way of the duodenum and to provide a pouch for greater food intake.

We have attempted to form a food pouch from a segment of the jejunum and have diverted the duodenal contents through a Roux-y anastomosis of the divided segments of the jejunum. This will be described later.

A brief review of the development and periodic changes in the technic of total gastrectomy are recounted.

Connor[4] in 1884, probably performed the first total gastrectomy.

Hoffman[5] in 1922, in an attempt to overcome some of the undesirable results of total gastrectomy, joined the two limbs of the jejunal loop to divert the duodenal contents and prevent reflux esophagitis.

This procedure was more extended in 1950 by Steinberg[6] and he described this wide anastomotic stoma between the proximal and distal limb of the jejunum as a pantaloon anastomosis.

Orr[7] in 1917 utilized the Roux-en-y principle to prevent reflux esophagitis, the distal limb of the Y being anastomosed to the esophagus in an end to side manner. This diverts the duodenal contents but does not provide any facility for increased food intake.

Lee[8] in 1951 substituted the right colon and a small segment of the terminal ileum for the removed stomach, anastomosing the terminal ileum to the esophagus and the colon to the duodenum and restoring intestinal continuity by an ileo transverse colostomy. This affords an adequate food pouch and the ileo cecal valve prevents reflux of duodenal contents into the esophagus.

Lee reports the procedures on sixteen dogs

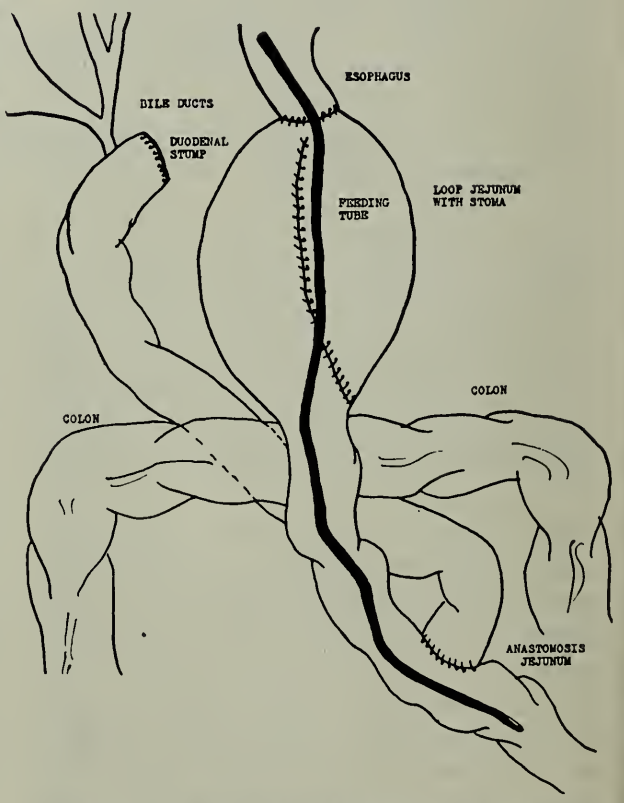


Figure 2. The completed operation showing the jejunal pouch anastomosed to the esophagus anterior to colon. Tube in place to below Roux-y for feeding by Murphy drip.

without any long time survival. The operation was reported successfully accomplished in one patient.

Hunnicut[9] in 1951 at the Western Surgical Association reported the successful use of this procedure in three patients.

State, Barclay and Kelly[10] in 1951 replaced the removed stomach by a segment of the transverse colon, in two patients. This transplanted segment of transverse colon presents the problem of reverse peristalysis which is reported by the authors as being an asset, as it prevents the passage of food too rapidly into the duodenum.

We[11] have attempted to overcome the undesirable features of total gastrectomy by employing the Roux-en-y procedure with the upper jejunum and at the same time constructing a food pouch out of either the proximal or distal segment of the jejunum.

Likewise, we[11] have replaced the stomach by a jejunal pouch made by doubling back on itself an end of the jejunal segment and making a stoma between the two parallel bowel limbs. This in turn is anastomosed to the esophagus and the duodenum. The proximal and distal jejunum after the segment is removed is reunited by end to end anastomosis. This makes a large food pouch and maintains the esophago-duodenal relationship through the transplanted jejunal segment.

Technique Of Operations.—After the stomach, great omentum and spleen have been freed of attachments and the duodenal stump closed, the jejunum is divided between clamps about 12-14 inches below the ligament of Treitz. The distal limb of the jejunum is brought up anterior to the colon and the end is doubled back upon itself in a side to side manner for about 6-7 inches. The sides of these loops are sutured together and an anastomosis with a full length stoma is made with the transected end of the jejunum being incorporated in the anastomosis, as shown in Fig. 1 and Fig. 2. This forms a large pouch which is then anastomosed to the esophagus by interrupted silk suture and continuous oo chronic catgut. The placing of the posterior rows of sutures is facilitated by traction on the attached stomach. After the posterior rows of sutures are placed, the stomach is excised above the cardia and the anterior rows of sutures are placed.

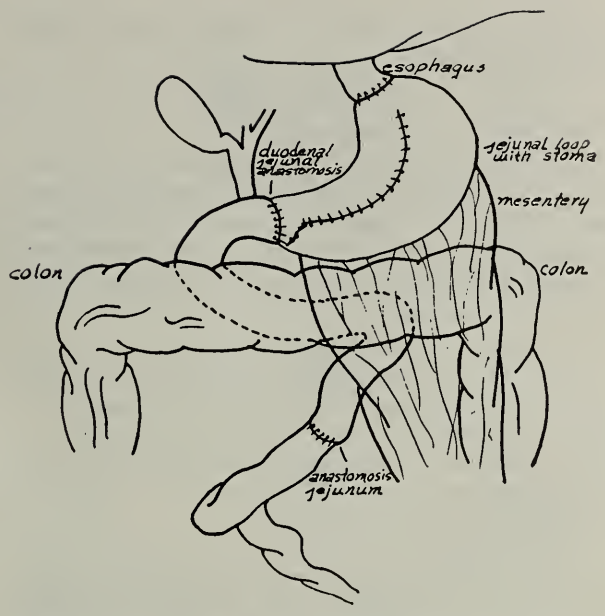


Figure 3. Shows the construction of a pouch from an isolated loop of jejunum which has been anastomosed to the esophagus and the duodenum.

The anastomosed pouch is further supported by sutures to the diaphragm and surrounding peritoneum to relieve tension.

The proximal jejunum is then anastomosed to the side of the distal jejunum well below the pouch. Fig. 2 shows the closed pouch anastomosed to the esophagus and the end to side anastomosis of jejunum to jejunum.

A Levin tube which has been in the esophagus is passed down through the pouch well down into the jejunum below the Roux-en-Y anastomosis and is useful as a means of administering fluid and feedings by the Murphy drip, in the postoperative period.

This procedure of using the distal segment of the jejunum for the food pouch diverts the duodenal contents to the jejunum below the pouch and prevents reflux esophagitis.

We have formed a food pouch to replace the stomach similar to the one described above by using an isolated loop of jejunum with its mesenteric attachment maintained. Then the pouch is anastomosed to the esophagus and the end of the jejunum to the duodenum. The jejunum from which the isolated segment was removed is united by an end to end anastomosis, illustrated in Fig. 3. This appears to be a feasible way of substituting for the stomach a food pouch made from the jejunum that more closely approximates a normal anatomic relationship.

Figs. 4 and 5 shows the capacity and emptying of the pouch.

CASE RECORDS

CASE NO. 1 — Hospital #55719

Mr. T. DeL., age 53 was admitted to Research Hospital on 2/18/50 complaining of epigastric distress and fullness on eating, difficulty swallowing and weight loss of 15 lbs. X-ray examination revealed a large filling defect involving the fundus and the entire lesser curvature.

The patient was prepared for gastric surgery and on 2/2/50 a total gastrectomy with removal of spleen and greater omentum and 3 cm's of esophagus was performed through a thoraco-abdominal approach. A food pouch was constructed from a loop of jejunum as described in the text. A Levin tube was passed into the jejunum beyond the pouch.

Tube feedings were started on the third day and the tube was removed on the tenth day and feedings started by mouth. The patient had an easy postoperative course and was dismissed from the hospital on 3/13/50.

The pathologist reported a Grade 3 adenocarcinoma of stomach involving lower portion of esophagus and the upper half of stomach with metastases to all nodes. The patient gained 9 lbs after operation, was holding down his former job and was eating 3 normal meals daily. On some special occasion recently, the patient drank 2 bottles of beer, followed it with a t-bone steak, french fried potatoes, a toss salad and dessert. This condition of apparent good health continued without distress or any evidence of an esophagitis until October 1951. He gradually developed adominal distention and a progressive anuria. He died November 12, 1951 from uremia and colon obstruction due to peritoneal pelvic metastasis. Autopsy revealed a large uninvolved jejunal pouch — a patent esophageal stoma and abdominal pelvic metastasis.

CASE NO. 2 — Hospital #60056

Mr. W. R., age 75, was sent to Research Hospital on 9/12/50 with a diagnosis of carcinoma of the stomach. X-ray examination showed a large lesion involving the fundus and the lesser curvature extending up to the cardia.

On 9/16/50 after adequate preparation, a total gastrectomy with removal of the spleen and greater omentum was done through an upper left rectus approach. The glands around the celiac axis were removed and a jejunal food pouch was constructed.

Tube feedings were started on the 3rd day and on the 9th day, food was given by mouth. The patient had a satisfactory postoperative course and was dismissed from the hospital on 11/18/50 after a convalescent stay of 3 weeks. The pathological report was Grade 4 carcinoma involving entire stomach and adjacent glands.



Figure 4 — Case 1. This shows the capacity and appearance of the jejunal food pouch three weeks after surgery.



Figure 5 — Case 2. The capacity and emptying of the food pouch as visualized three weeks after operation.

CASE RECORD

Case Initials	Age	(Research) Hosp. No.	Date Oper.	Path Report	Complications	Operative Mortality	Duration of Life	Deceased
1. Mr. T.D.	53	55719	2/22/50	Grade 3 adeno carcinoma	None	None	20 months and 18 days	11/12/51
2. Mr. W.R.	75	60056	9/16/50	Grade 4 scirrhous ca	None	None	17 months 12 days	2/28/52
3. Mrs. M.M.	57	63776	3/17/51	Grade 3 adeno carcinoma	Insolvent transverse colon necessitating resection and later cecostomy. Cecostomy closed later.	None	13 months alive and in good health	
4. Mr. W.K.	74	65841	3/7/51	Grade 3 adeno carcinoma	None	None	10 months — Alive	
5. Mr. A.R.	78	66055	6/21/51	Grade 3 adeno carcinoma	None	None	10 months. Alive	
		(Wheatley)						
6. Mr. S.T.	65	25034	7/13/51	Grade 3 adeno carcinoma	None	None	9 months. Alive	
7. Miss E.G.	65	68849	10/22/51	Grade 3 adeno carcinoma	Small bowel obstruction. Operative release.		1 month 22 days	12/14/51 Coronary Thrombosis

Case I — Approach was through a thoraco abdominal incision.

Case III — A segment of the transverse colon was resected along with the stomach. Continuity was re-established by end to end anastomosis. Cecal distention developed. Cecostomy was done on the third P. O. day to prevent possible perforation of the suture line. Cecostomy subsequently was closed.

Case VII — Postoperatively small bowel obstruction developed. This was released surgically. Both operations done by Dr. W. W. Cummins of our group.

NOTE: All patients on unrestricted diet. Gain in weight 5/12 lbs. after operation.

On 11/10/51, (11 months after surgery) patient reported that he was eating 3 normal meals a day with nourishment in midafternoon and was feeling fine. He is about as active as before surgery and recently took part in his State Fair. He has had no epigastric distress or regurgitation. Deceased February 28, 1952, intestinal hemorrhage. No autopsy.

CASE NO. 3 — Hospital #63776

Mrs. M.M., age 57, was admitted to Research Hospital on 3/4/51 with diagnosis of cancer of the stomach. Patient had much gastric distress and had lost 25 pounds weight. X-ray examination revealed an extensive lesion of the pars media and the lesser curvature of the stomach.

At operation 3/7/51, an extensive cancer of stomach with involvement of transverse colon mesentery and the colon by continuity were found. A total gastrectomy with removal of the spleen, adjacent nodes and the segment of involved transverse colon and its mesentery were done. A jejunal food pouch as described was constructed and an end to end anastomosis of the transverse colon was accomplished.

Tube feedings were continued until the 9th day. Because of an alarming distention of the cecum, a cecostomy was done on the 3rd day. The patient had a very smooth postoperative course and was dismissed on 4/1/51.

The pathologist reported a Grade 3 adenocarcinoma of the stomach involving the proximal half. Segment of colon involved by continuity.

Four month later on 8/4/51, the patient was readmitted for closure of the cecostomy. She was eating three meals a day with midmorning and afternoon feedings and has gained four pounds. Her main complaint was that the cecostomy acted every time she ate. After closure of the cecostomy on 8/8/51, this disquieting occurrence was eliminated. There had been no regurgitation or evidence of esophagitis. Report on April 24, 1952 is satisfactory.

CASE NO. 4 — Hospital #65841

Mrs. K., age 74, entered Research Hospital 6/3/51. X-ray examination revealed a large polypoid lesion involving greater and lesser curvature in the pars media of the stomach.

On 6/11/51, through a transverse incision, a total gastrectomy with removal of greater omentum and spleen was done and a jejunal food pouch was constructed. Tube feeding were begun on the 4th day and oral feedings on the 10th day. She had an uneventful postoperative course and was dismissed on 7/1/51.

Pathology report was a reticulo-cell sarcoma involving most of the stomach and invading the gastro-colic and gastro-hepatic omenta.

Patient was seen and x-rayed on April 20, 1952 and found to be feeling well. Twelve pounds gain in weight. X-ray showed a large functioning food pouch. She eats three substantial meals a day with protein milk in midmorning and afternoon.

CASE NO 5 — Hospital #66055

Mr. A. R., age 78, was admitted to Research Hospital on 6/13/51 because of three gastric hemorrhages in the past two months. The radiologist reported a large filling defect in the pars media of the stomach.

After several transfusions the patient was operated on 6/21/51 at which time a total gastrectomy with removal of greater omentum and a portion of transverse colon mesentery was done. A jejunal food pouch was constructed.

Tube feedings were started on the third day and oral feedings on the seventh day. Patient was dis-

missed on 7/5/51 in good condition. The pathologist reported a large grade 3 carcinoma of the pars media with ulceration and penetration of the anterior wall of the stomach. Now, ten months from date of operation, patient has mediastinal pain, probably extension. Otherwise looks well.

CASE NO. 6 — Hospital #25034

Mr. S. T., a 65 year old colored man was admitted to Wheatley Hospital on June 6, 1951 with a large carcinoma involving the upper half of the stomach. On July 13, 1951 a total gastrectomy with construction of a jejunal food pouch was done by Dr. W. W. Cummins of our group. A Levin tube was passed down into the jejunum and tube feedings were given for 6 days and oral feedings were then started. The convalesence and postoperative course were without incident and patient was discharged on the ninth postoperative day.

The pathologist reported an extensive Grade 3 carcinoma involving the fundus, cardia and lesser curvature of the stomach with involvement of one adjacent lymph gland.

On last report in March 1952, this patient is taking 3 fairly substantial meals a day with nourishment in midmorning and afternoon.

CASE NO. 7 — Hospital #68849

Miss E. G., a white female school teacher age 65, was admitted to Research Hospital October 17, 1951 with a chief complaint of epigastric pain and dyspepsia with loss of appetite over a period of 6 months. Weight loss of eighteen pounds past six months, Hb 67%. She was given two 500cc transfusions. X-ray reported a large ulcerated area on lesser curvature of stomach. On 10/22/51 a total gastrectomy with spleenectomy and resection of all available glands around the coeliac axis was done. A food pouch of jejunum was constructed in the manner given above and the Levin tube brought down the distal loop for purposes of feeding fluids. At the time of operation no metastases were present in the liver. Pathologist reported a large carcinoma of the stomach involving a small portion of the lower esophagus.

The postoperative course was uneventful until the 6th postoperative day at which time the Levin tube slipped up and was removed. Following this, the patient began to regurgitate intestinal contents and some thin barium was swallowed which showed immediate passage through the food pouch. The radiologist believed the obstruction due to spasm or incomplete obstruction and a waiting course was followed until 11/5/51 at which time, since patient continued to vomit on occasions, it was decided that a true obstruction of the small bowel existed.

The old incision was reopened and an adhesive constricting band involving the lower small bowel was found and released.

The constricted area did not expand readily so an entero entero-anastomosis was done. The patient reacted well and was taking food and up and about on the 2nd postoperative day. Other than for slight drainage from the incision the patient had an uneventful recovery and was discharged from the hospital November 15, 1951. Patient expired on December 14, 1951. Coronary thrombosis — autopsy.

COMMENT

This technique has been used by us in seven consecutive cases without mortality or undue morbidity. In each case a Levin tube was passed into the jejunum well below the Roux-en-Y anastomosis for feeding purposes and was left in place an average 9 days. In none of the cases was there evidence of a leak at the site of anastomoses.

None of these patients have complained of reflux esophagitis and all have taken progressively more food with the passage of time with corresponding slight gain in weight.

One case, postoperatively had distention of the proximal colon after an associated transverse colon resection. Cecostomy was done which was subsequently closed.

One case developed small bowel obstruction which was surgically relieved. It is not our belief that any of these patients have been cures because of the extent of the lesion in each case.

We present the technique with the belief that it provides an adequate pouch for food intake, lessens requirements for frequent feeding, provides facilities for balanced diet and diverts duodenal contents and lessens incidence of reflux esophagitis.

Colon—Closed Versus Anastomosis.—Modern preparation of the non-obstructed colon, the use of antibactericidal drugs and the improved surgical technique have made open colon anastomosis a relatively safe procedure.

The essentials for open anastomosis are: A non-obstructed clean bowel, intestinal antibiotics, bowel approximation without tension and an uncompromising blood supply.

Peritonitis does not develop from an adequately prepared bowel. It results from: A bowel unsuitable for opening, an insecure anastomosis, tension on the suture line, localized necrosis from an inadequate blood supply or local strangulation of tissue in necrosis and leakage.

The advantages of an open anastomosis are: Excision of presenting polyps, suture under direct vision, accurate control of hemorrhage and a minimal of invaginated diaphragm.

Colon X-ray.—An x-ray film of the obstructed colon does not give as much information as in

obstruction of the small bowel. It does show a distended proximal colon with its characteristic Haustral markings but the exact site of the obstruction is relatively uncertain. Localization of the lesion can be determined by a barium enema. If the obstruction is complete it is then no obstacle to surgery. It can be readily evacuated by enema. It is only when the obstruction is incomplete that subsequent difficulty may be encountered by barium enema. The proximal colon may become impacted with dehydrated barium. It may convert an incomplete obstruction into a complete one.

Barium should never be given by mouth in obstruction of either the small or large bowel.

As the colon becomes more distended because of the closed loop nature of the obstruction, the characteristic Haustral markings become less evident. These Haustral markings in contrast to the valvulae conniventes of the small intestines are fine points of radiological interpretation and are easily detected by a competent radiologist.

The progressively distended colon is usually a closed loop obstruction, in which the blood supply soon becomes inadequate to maintain bowel viability. The segment of the colon most subject to extreme distention is the cecum, the walls of which become extremely thin and ultimately may become gangrenous and perforate. This closed loop type of colon obstruction is, therefore, in part comparable to a strangulated or a volvulus type of small bowel obstruction. It is in reality as much of an emergency as small bowel strangulation. Therefore, surgical decompression should not be long deferred, else gangrene and rupture of the cecum may occur.

Surgical Principles.—Colon obstruction presents a complication that prohibits a primary attack upon the lesion. This is quite in contrast to that of small bowel obstruction. In colon obstruction the problem is to decompress the colon and prepare it for subsequent resection of the lesion, while in small bowel obstruction, surgery is directed primarily toward removal of the lesion.

Sites For Decompression.—Obstructive lesions of the right colon may be decompressed by cecostomy or by ileo-colostomy. Ileo-colostomy is desirable and sufficient when the obstruction is incomplete or when fixation or inflammatory reaction is present. Obstructive lesions at the ileo-cecal region result in small bowel distention that often may be decompressed by the Miller-Abbott tube.

Surgical decompression for distal lesions can be done by cecostomy or transverse colon colostomy, the latter being preferable if the lesion is low in the left colon. However, in complete obstruction with extensive proximal bowel distention this is not always easy or without danger. Often the distended right transverse colon is pushed high under the liver by the enormously distended cecum which displaces everything well towards the midline and upward, so the transverse colon is difficult to approach and deliver.

The paper thin bowel wall will not withstand trauma and it is wise to decompress the colon at the most approachable point. This usually is the cecum. The procedure is a life saving measure and safety should not be comprised because of efficiency of subsequent colon irrigation. The left colon can be irrigated and cleaned through a cecostomy but not as easily as through a colostomy.

Proximal decompression for obstructions in the upper left colon or the splenic region should be by cecostomy. Right colostomy would limit the scope of subsequent surgery.

Mortality.—Brindley[12] reports seven deaths in 34 cases of acute malignant obstruction, 20.6%; Gregg and Dixon[13] — 121 cases, 34.7%. We had four in 15 cases, 26.6% and none in 18 others, performed by our present method, using our special colostomy clamp.

Loop Colostomy.—Loop colostomy is difficult to do in acute colon obstruction. The enormously distended colon can not easily be elevated above the skin level to be supported by a glass rod. Decompression by needle aspiration before elevation opens an avenue for contamination through the site of needle puncture. Manipulation is attented by some danger. Bleeding may be encountered from the mesentery by passing a supporting rod; pressure may cause subsequent bleeding or bowel necrosis.

Catheter insertion into the cecum is attended by great danger of spillage. It offers poor facilities for future bowel irrigation. We have abandoned both procedures in acute obstruction of the colon for the one we now describe.

Procedure For Colon Decompression.—In acute colon obstruction we deflate the distended bowel by needle puncture through a cecostomy or

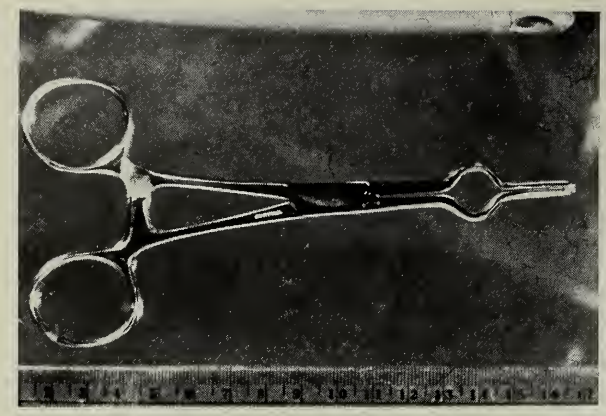


Figure 6 — Clamp and Catheter Manufactured by V. Mueller & Co., Chicago, Ill.



Figure 7 — Suspending cone of deflated cecum preparatory to applying cecostomy clamp.

colostomy incision. The deflated bowel is grasped at the point of needle puncture with a flat no tooth thumb forcep and our special colostomy clamp is applied to the suspended cone of bowel. We then proceed to completely close the abdomen around this protruding segment of colon. We open the protruding knuckle of bowel and insert into the colon through the round opening in the clamp an 18 or 20 F. catheter. This procedure exteriorizes only a small segment of the colon but gives an adequate vent for gas to pass through the catheter.

If the colon contains mostly liquid material and little gas it may be deflated sufficiently to apply the clamp, (pack around it to protect against spillage and contamination) open the cone of bowel protruding through the ring of the clamp and insert a large size catheter, suture and ligate the bowel tightly around the catheter and irrigate it sufficiently to deflate it adequately for exteriorization.

The clamp can be removed in two or three days after the bowel has adhered to the abdominal wall and bowel irrigations may be started. This procedure does not completely divert the fecal current. It is advocated for an acute obstruction, due to cancer, where resection is subsequently contemplated and for acute colon obstruction resulting from extrensic malignancy.

Figure 6 shows clamp and catheter.

Figure 7 shows the blunt thumb forcep grasping the bowel at the site of needle puncture. The clamp with round ring is being applied and a cone of bowel is shown above the clamp.

Figure 8 shows the clamp in place and catheter inserted through opening in clamp into the bowel. The abdomen was completely closed before opening the bowel and inserting clamp.

The catheter acts as a vent largely for gas and prevents redistention of the bowel. The clamp is removed later or it sloughs off and the bowel is then irrigated and cleansed. The method is

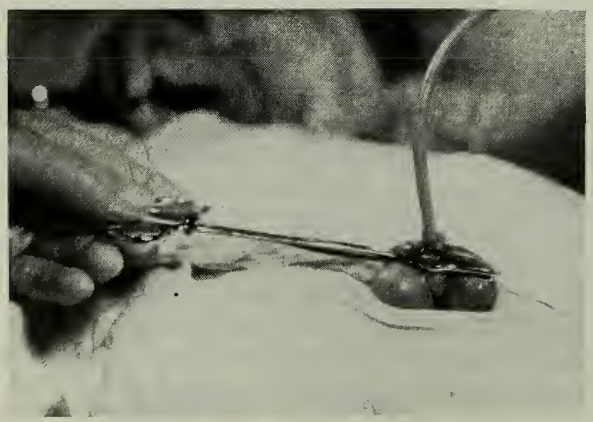


Figure 8 — Tube in position through ring of clamp into bowel. Gives vent for escape of gas — bowel will not redistend. Bowel will retract to near skin level.

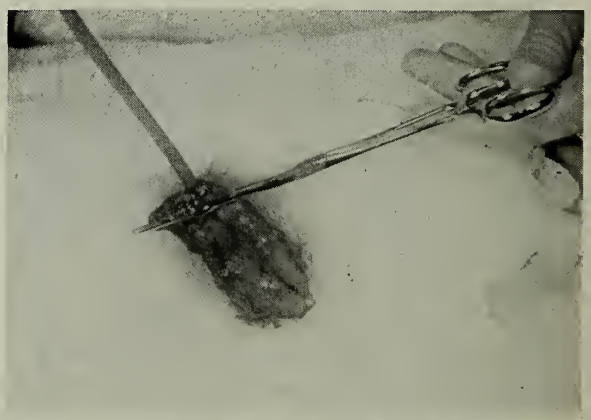


Figure 9 — Clamp useful for catheter insertion to prevent distention of the colon after abdomino-perineal resection.

simple, practically aseptic and performed without difficulty. There is no contamination. It is extra peritoneal.

Figure 9 shows the clamp applied to the protruding bowel of an abdomino-perineal resection with catheter inserted to prevent distention.
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Surgical Problems in the Aged

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Since the average life span of man has increased to 68 years, there are now according to Bortz[1] approximately 12,000,000 people in the United States who are 65 years old or more, or one in every 13 persons. This vast number of persons face many problems other than surgical which means that specialists in internal medicine, cardiology, neuropsychiatry, arthritis, orthopedics, and ophthalmology will be more in demand than the general surgeon. In our experience the general surgeon encounters largely those who are active and require little or no attention because of the infirmities of old age and are not too handicapped by any serious associated disease.

The question is frequently raised "What do we consider old?" This depends upon one's viewpoint. It has been said that the old age of youth is the youth of old age. We all know that some are old at 35 and others are still young at 80 years. This concept is well expressed by the phrase that some are chronologically young but biologically old, while others are chronologically old but biologically young. However, in order to discuss the surgical problems of the aged the author feels that an arbitrary age must be designated for the sake of discussion. Just what this age should be depends again upon the individual viewpoint. The author feels that 70 years should be the minimal age instead of 60 or 65 years usually referred to in the literature. To this end the author chose as a basis for this discussion a group of 109 patients 70 to 94 years old with an everage age of 75.1 years. These 109 patients represent consecutive operations performed by the author during the past 5 years. Surgical diseases in the field of gynecology, ophthalmology, and thoracic surgery are excluded and also for the most part, urologic and orthopedic surgery.

This group must be considered chronologically old but biologically young. For the most part, the conditions requiring surgical intervention in

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Table 1

This table represents the overall hospital mortality of 109 patients according to age groups, sex and type of operation.

Age	Total Number	M.	F.	Major Oper.	Minor Oper.	R.	D.	Mort.
70-74	58	29	29	56	2	58	0	0.0%
75-79	35	24	10	33	2	31	4	11.0%
80-84	11	5	7	11	0	8	3	27.2%
85-90	4	3	1	4	0	4	0	0.0%
90-94	1	1	0	1	0	1	0	0.0%
Total	109	62	47	105	4	102	7	6.4%

the aged are no different from those encountered in the middle or even younger age groups. There is one striking difference; practically all the surgical diseases in the aged are major. Only 4 patients (Table 1) out of 109 had minor operations.

Table 2 indicates the surgical diseases most common in the aged. Almost half of this series had malignancy: 45, or 41.3 percent were so affected. Nine of the 45 had lesions considered by the author to be inoperable; or, 1 in every 5 patients. On the other hand, more aggressive surgeons might have considered some of these malignancies as operable. Of the 9 inoperable patients, 3 had carcinoma of the pancreas, 2 of the colon, and one each of the stomach, liver, and right kidney; 1 had abdominal Hodgkins disease. If we exclude the 9 patients with inoperable malignant lesions, the remaining 36 (Table 3) with operable malignant conditions had the following operations: 19 had partial colectomies with 2 deaths; 5 had combined abdomino-perineal resections of the rectum with no deaths; 7 had subtotal gastric resections with one death; and 5 had radical mastectomies with no deaths. The mortality was 9 per cent. Coronary occlusion was the immediate cause of death of the 3 patients in this group.

The second most common surgical condition in the aged is biliary tract disease. In a total of 21 patients (Table 4), approximately 20 per cent suffered from gallstones and their complications. Jaundice was present in 10 patients, 7 of whom required drainage of both the gall bladder and the common bile duct, while 3 required drainage of the common bile duct alone. Each had had a previous cholecystectomy. In 8 patients the gall bladder was drained because of

Table 2

Surgical Conditions in 109 Consecutive Operations on Patients with an Average Age of 75.1 years.

No.	Aver. Age	Disease	M.	F.	Operable	Inoperable	Oper. Mort.
45	74.3	Malignancies	30	15	36	9	10.9%*
21	75.3	Biliary Tract	7	14	21	0	4.7%**
18	76.5	Intest. Obst. not Malig.	9	9	18	0	5.5%***
9	74.3	Peptic Ulcers Complications	6	3	9	0	11.1%#
5	74.6	Fract. Neck Femur	0	5	5	0	0.0%
4	73.2	Rectal Dis.	4	0	4	0	0.0%
3	75.7	Rupt. Append. Peritonitis	2	1	3	0	0.0%
3	75	Inguinal Her.	3	0	3	0	0.0%
1	70	Gangrene of Foot.	1	0	1	0	0.0%
109	75.1		62	47	100	9	6.0%

*Three deaths from Coronary Occlusion. **One death, empyema of the Gall Bladder. ***One death from Gall Stone Ileus. #One death from perforated peptic ulcer.

Table 3

Location of the Primary Lesions in the 36 Patients with Operable Malignancies. All were Cancers. The 9 patients with Inoperable Malignancies are not included in this Table.

No.	Aver. Age	Organ	Operation	Rec.	Died	Mort.
19	74	Colon	Partial Colectomy	17	2	10.9%*
5	73	Rectum	Comb. abd. per. Resection	5	0	0.0%
7	75	Stomach	Sub-total Resection	6	1	14.3%**
5	74	Breast	Rad. Mastectomy	5	0	0.0%
36	74.9			33	3	9.0%

*Death from Coronary Occlusion. **Death from Coronary Occlusion.

Table 4

The various Types of Biliary Tract Disease in 21 Patients.

No.	Aver. Age	Disease and Operation	M.	F.	Mort.
8	74.2	Gall Stones with G.B. Drainage	1	7	1 death
7*	79.6	Gall Stones with G.B. and C.B.D. Drainage	4	3	0
3*	72	C.B.D. Drainage with prev. Cholecystectomy	2	1	0
3	72	Gall Stones with Cholecystectomy	0	3	0
21	75.3		7	14	4.76%

*Obstructive Jaundice was present at the time of Surgery.

empyema or threatened empyema. The remaining 3 had simple cholecystectomy. The mortality rate of this group was 4.76 per cent. The one death resulted from advanced empyema of the gall bladder.

The third most common disease in this series (Table 2) was intestinal obstruction from causes other than malignancies. There were 18 patients in this group. Strangulated hernia either inguinal, femoral, or incisional accounted for 10 while 4 resulted from intra-abdominal adhesions from previous surgery, one of whom required resection of a segment of strangulated ileum. Gall stone ileus was present in 3 patients and volvulus occurred in one. The one death in this group was the result of gallstone ileus, operated too late. The mortality was 5.5 per cent.

The fourth most common surgical disease in this series consisted of the complications of peptic ulcer (Table 2), either duodenal, gastric, or stomal. A total of 9 patients has such complications. Four required subtotal gastric resection of which 2 had gastric ulcers, 1 had an obstructing duodenal ulcer, and a fourth a bleeding, penetrating and obstructing stomal ulcer requiring both jejunal and gastric resection. Simple gastroenterostomy for obstructing duodenal ulcers was performed in 4 patients. One patient was operated upon for a perforated duodenal ulcer that was treated by simple closure in a patient 80 years old. In this group one patient died three weeks after simple gastroenterostomy for a high grade obstructing duodenal ulcer. She had been discharged from the hospital one week previously, but was brought back in severe shock and died a few hours after admission from what resembled a perforated peptic ulcer. Autopsy was not permitted to confirm this diagnosis.

Other less common surgical conditions met with in general surgery (Table 2) were as follows: 5 patients with fractures of the neck of the femur treated by open operation and nailing; 3 had a ruptured gangrenous appendix with peritonitis; 3 had uncomplicated inguinal hernia, and 1 had gangrene of the foot. The four patients with minor surgery had some form of local rectal disease. There were no deaths in this group.

A survey of this entire series of 109 patients whose average age is 75.1 years, reveals an overall hospital mortality of 6.4 per cent; (or 6 per cent if only the 100 operable cases are counted). It appears that there is little difference in the surgical problems of the aged and of the younger age groups. The opinion that "the patient is too old to be operated upon" no longer has any place in modern surgical thought. The author for years has held steadfastly to the view that regardless of the patient's age, he is entitled to the same surgical considerations as is given to younger person when faced with the same major surgical disease. Moreover, any patient regard-

less of age, who is active, is able to look after himself, and maintains an average state of nutrition presents no grave surgical problem when a major operation becomes necessary. However, because aging tissues have a loss of flexibility and because of the frequently associated pathology, we feel that additional caution is wise in managing the aged when they face a serious surgical procedure. It is significant that in this series 3 of the 7 deaths were the result of associated pathology (coronary occlusion) while the remaining 4 died as a direct result of the primary disease. Nevertheless, the author feels that for the overall picture, it is important to emphasize some of the fundamental principles involved in the preoperative, operative, and postoperative care of the oldster. The objective in doing surgery is to save health and thereby prevent invalidism and to save lives if no other alternative exists. To carry out such a program successfully the author wishes to present some of the basic principles of surgical management.

(1) The average geriatric patient should have, whenever possible, the services of both a competent internist and a competent surgeon. If the series herein presented indicates a low mortality, much credit goes to the internist whose understanding of the altered physiology in the aged has been most helpful. In a similar way the surgeon must know the anatomic alterations that accompany old age and devise a safe surgical approach in major surgical problems.

(2) Assuming that the diagnosis has been made as well as the decision on whether surgery is elective or emergency, it is important to inform the patient of the gravity of his condition. Regardless of the risk, if the patient has been otherwise well, he may be given much assurance that his chances of surviving surgery are extremely good. If the condition is an emergency, one can only hope for the best.

(3) In case of elective surgery, besides the usual routine laboratory studies, a complete blood chemistry is indicated. This is necessary because some of the usual physiologic functions may be deficient and if so, they can be compensated for through proper therapy before undergoing the stress and strain of major surgery. In other words, in the event of a disturbed electrolyte balance or a hypo-proteinemia, proper steps may be taken to correct these disturbances with a high carbohydrate and protein diet and even blood and plasma if necessary. Furthermore, vitamin studies are helpful because frequently the eating habits of old people are inconsistent and many times certain vitamin deficiencies exist, which must be corrected.

(4) Electrocardiographic studies should be made routinely to determine cardiac function. Since the capacity of the circulatory tree is more or less fixed in the aged, fluid administration parenterally must be cautiously given at all times to prevent excessive heart strain.

(5) Preoperative medication should be given judicously whether the operation be major or minor. The average dose of the various narcotics, as a rule, is too large for the elderly and the amount, therefore, should be reduced. The insertion of a Foley catheter to facilitate urinary output and the introduction of a Levine tube for continuous Wangensteen suction are essential measures before going to surgery.

(6) The administration of the anesthetic demands an experienced anesthetist, whether a graduate nurse or a graduate in medicine. The margin of safety, or the zone between stability and instability of the aged while under anesthesia, often is narrow. The author feels that the anesthetist should choose the type of anesthetic agent best suited for the particular patient. The low mortality rate in this series of patients reflects in no small part the efficient work of the anesthetists.

(7) During the course of the operation intravenous fluids (preferably blood if the operation is major), is a necessity to compensate for fluid and blood loss. Here it becomes the duty of the anesthetist to estimate the amount of blood loss and at the same time determine the amount of replacement. This constitutes a grave responsibility for the anesthetist because the blood vessel walls in the older person have lost much of their former contractibility and cannot tolerate variations of blood volume either in excess or below the normal level.

(8) The surgeon must be qualified both from the standpoint of surgical judgment and technical skill. If the surgeon can accomplish what he hopes to by a more conservative method, such a method should be employed. On the other hand, if a more radical procedure becomes mandatory to give the aged patient his only chance for cure, then it should be used. Regardless of the outcome the procedure will have been justifiable.

(9) Alert and experienced care by both the nursing and surgical staff in the immediate postoperative period frequently determines the success or failure of the operation. The so-called "recovery room", if available with a competent personnel is a great asset. Furthermore, frequent blood pressure readings and change of position, free movements of the arms and legs, deep breathing and coughing exercises, and early ambulation preferably starting the day of surgery, are of the utmost importance. Sedation should be light, never deep. It is much better to permit the patient to have some pain and discomfort to assure body movements. A single sedative is preferred to combinations of several. All sedatives should be written as a single order. Permission for repeat orders ought to be given only after the patient has been seen by a member of the surgical staff.

(10) The maintenance of an adequate fluid and electrolyte balance requires constant vigilance. Hydration which places undue strain upon cardiac activity must be guarded against. It is better to keep these patients on the slightly dehydrated side of the ledger. Cardiac as well as respiratory stimulants may be indicated, but should never be made standing orders but given as single orders.

(11) The value of continuous Wangensteen suction during the postoperative period to maintain gastric and upper intestinal decompression cannot be overemphasized. This permits fluids by mouth freely as soon as the patient regains consciousness which is very gratifying and relaxing to the patient. At the same time continuous suction prevents postoperative vomiting as well as tracheal and bronchial aspiration and thus may prevent serious pulmonary complications. The suction apparatus must be in constant working order, otherwise far more harm than good is accomplished.

(12) The use of vitamins should not be overlooked. If they have been indicated preoperatively they are all the more indicated postoperatively. As to the use of antibiotics, the author feels that they have only limited value unless there exists active infection in the surgical field, or the field is potentially contaminated. The surgeon must constantly be on the alert for any undesirable reactions, and should they occur, antibiotics must be stopped at once.

CONCLUSION

In this study we have made no attempt to cover all the clinical details incident to surgery in the aged. However, we have attempted to set forth the various surgical diseases requiring major surgery in 109 consecutive operations on patients whose average age was 75.1 years. Furthermore, evidence has been presented that this series did not offer any more serious problems, than might be offered by a younger age group with similar diseases; the overall hospital mortality of only 6.4 per cent gives satisfactory proof of this view.

Advances in modern surgery, whether surgical judgment, technical skill, safety of anesthesia and its expert administration, electrolyte balance, plasma and blood transfusions, antibiotics, sulfa drugs, or nursing care that has reduced the mortality in surgery in general has in a similar way benefited the aged. It probably cannot be said that the aged of today are more rugged and can tolerate major surgery better than the aged of yesterday. There are so many more old people living today than ever before, who are enjoying the many advances of modern surgery. The author feels that the hopeful attitude assumed today by both patient and surgeon toward surgery in the aged and the many great advancements in medical science during the past several decades are both masterfully reflected in the low mortality rates in major surgery of the old people today. It, therefore, would not be improper to assume that most all the problems of major surgery in the aged have been solved and that the phrase "he is too old to be operated upon" no longer holds the place it once did in the horizon of surgical thinking.

Some Features of the Pathological — Physiology of Congestive Heart Failure

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The extensive use, in recent years, of physiological techniques in the clinical investigation of cardiac failure has added very considerably to our quantitative knowledge of this condition. The applied techniques are particularly those which allow the determination of the cardiac output and an evaluation of kidney function.

The failing heart may be considered to be a heart the output of which is not sufficient to meet the needs of the tissues and is due, at least in part, to abnormally inadequate myocardial contractile performance. The normal heart, on the other hand, adjusts its output to meet the needs of the body tissues. These normal adjustments are nervous, humoral and myocardial and can cause increased heart rate and increased stroke volume, both of which can result in the increased output necessary to carry the increased oxygen which the body requires in its daily activities. Increased heart rates, within normal limits, can about double the cardiac output. Increased stroke volume can also double the output. The effect of these combined can at least quadruple the resting output. In the failing heart the stimuli to these adjustments is probably usually present but the myocardial contractile response is inadequate and the delivery of oxygenated blood to the tissues does not meet their needs.

The contractile force of the heart depends (importantly) upon its diastolic muscle fiber length and this depends (importantly) upon the venous pressure. A rise in venous pressure results in an increase in cardiac output (Starling's "law of the Heart"). This mechanism in the normal heart is very sensitive; slight rises in venous pressure, within the limits of normal variation, cause comparatively large rises in cardiac output. This ascending portion of the curve is the range of physiological adaptation.

This mechanism has its limits, as the venous pressure rises progressively the cardiac output reaches a peak and then, in spite of continued rises in venous pressure, the cardiac output falls. In this, the descending portion of the curve, increases in venous pressure cause overloading, overextention of the cardiac musele fibers, and low levels of cardiac output. In the failing heart, with a pathologically deficient contractile force, this fall in output with rise in venous pressure may occur at, a little above, or below, the normal resting cardiac output.

Cardiac failure may be divided into two categories: "low output failure" and "high output failure". The more common of these, "low output failure", is related primarily to the heart itself: rheumatic, hypertensive, arterio-sclerotic, coronary and luetic heart diseases. In these conditions the output is lower than is normally required. In these conditions the venous pressure tends to be elevated. Up to a point this increased venous pressure tends to cause increased output and is beneficial, but too soon the point is reached where increased venous pressure tends only to cause decreased outputs.

In contrast "high output failure" is related to diseases primarily outside of the heart itself: chronic anemia, beri-beri, chronic anoxia, thyrotoxicosis (probably), and arterio-venous fistula, Paget's disease and some congenital heart disorders. In these conditions the transportation of sufficient oxygen to the tissues can only be accomplished by high cardiac outputs. The stimulus to these high outputs is oxygen need. The heart may perform this increased work satisfactorily for long periods of time but eventually it may suffer contractile weakness and cardiac failure intervenes. As the needs for oxygen are undiminished and as the stimulus to a high output still remains, the cardiac output is still found to be above normal but, in failure,

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still inadequate. The venous pressure may rise and, as the heart is pathological, the rise in venous pressure may only result in decreased cardiac output.

In both of these conditions some aspects of kidney function become abnormal. It has been found that in congestive failure the blood flow through the kidney is markedly reduced (1). This same reduction in kidney blood flow occurs in exercise (1), and whatever its mechanism seems to be a response to relative oxygen lack. Accompanying this reduction in renal flow there is a decrease in glomerular filtration and, for whatever reason, there is a decreased excretion of sodium (1). This retention of sodium by the kidney is accompanied by the retention of an excess of water in the body especially in the extracellular spaces, i.e. the interstitial spaces and in the blood (2). This tendency of the blood volume to rise is considered to be partly responsible for the rise in venous pressure in failure.

A vicious circle may occur. Inadequate output tends to result in increased venous pressure and the increased venous pressures, in these pathological conditions, result in still further reduction in cardiac output.

Rational therapy is based upon the pathological-physiology involved. In the first place rest is of importance. Rest reduces the oxygen need, reduces the requirement for cardiac output, reduces the venous pressure and should improve renal hemodynamics. The use of the digitalis compounds has an important role in increasing cardiac efficiency (3), increasing output, reducing venous pressure (4), and improving kidney blood flow. The use of sodium restricted diets or of mercurial diuretics, which act to increase sodium excretion, accomplish a decrease in circulating blood volume and again a decrease in venous blood pressure. The therapeutic use of venesection in the treatment of low output failure has been investigated (5); it has been found that the withdrawal of about 500 c.c. of blood resulted in a reduction in venous pressure and improvement in cardiac output and in symptomatology.

Another illustration of the effects of changing the venous pressure has been observed (6) in an instance in which packed red blood cells were given to a patient with chronic anemia and incipient congestive failure. The giving of the red cells raised the venous pressure, reduced the cardiac output and precipitated severe cardiac failure.

In conclusion: In congestive heart failure the cardiac output is not sufficient to meet the body needs for oxygen. There results a rise in central venous pressure due to resistance of the heart to filling and to a retention of sodium and its accompanying water by the kidney. This stimulus to increased contractile force, may within limits be beneficial, but in the abnormal heart with its inadequate contractile mechanisms it may lead to decreased force of beat and reduction in cardiac output. Modern treatment, as yet far from completely adequate, has as its aim the correction of these faults.

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Bronchoscopy Re Bronchitis and Chronic Pulmonary Abscess

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In reeent years the chronic type of eough or bronchitis has beeome a matter of increasing eoncern to the general publie. Before the advent of laryngoscopy, bronchoscopy, esophagoscopy, thoracic surgery, chemotherapy and the antibiotic drugs, conflieting views on various aspects of the problem had been expressed by different investigators and laryngologists. Henee the idea of this paper with a case report illustrating the importanee of bronchoscopic diagnosis, aspiration and chemotherapeutic endoscopic treatment in sueh cases.

Generally speaking, bronehitis superimposed upon emphysema, pulmonary absecss, pulmonary fibrosis or bronchieetasis, may so obstruet the bronehial passages that respiratory failure and death could easily result. Thus we may think of the extreme eonditions as follows: The exudate and loeal edema of an extensive bronchitis produee more and more bronchial stenosis and obstruction. The lungs, in an attempt to increase an interchange of air, greatly increase negative pressure during the aet of inspiration, bringing about inereased bronchial seeretion and exudate. Should anoxemia become extremely progressive, eerebral centers naturally beeome involved or depressed until the eough reflex are is abolished; and death may oeeur by suffocation.

In reviewing the literature on sueh eonditions one is partieularly impressed coneerning the mistaken diagnosis in eonneetion with such dramatic symptoms as eyanosis and laborious dyspnea — frequently diagnosed as pneumonia or left ventrieular heart failure. However, a earefully made history will undoubtedly reveal the true picture of the case. For instance, the patient's age is generally past forty-five and for a number of years there has been bronehial eough with the familiar type of expectoration, more or less asthmatic wheezing and slight dyspnea on exertion. The history also reveals that the patient began with the complaint of a seemingly trivial upper respiratory tract infeetion; the family doetor called it a "cold" and "sinus trouble". Here again, fundamental differenees exist in reference to chronicity of the case. A eonsiderable number of patients admit negligence, plead poverty and indulge in self-pity. Some had their eondition diagnosed as bronehial asthma and were advised to live in Arizona.

But the laryngoscope and bronchoscope have revolutionized the entire conception of bronchial obstruction. It is well to remember that before the advent of endoscopy, autopsie studies revealed bronehi obstrueted by alterations in tissues or by the products of sueh pathologic alterations. It was then realized that absorption by the circulatory apparatus could bring about atelectasis in the tributary bronchi; but observing the living air passages under bronchoseopy reveals the faet that bronehial obstruction in the living is of the valvular type. In this connection we are reminded that such obstructions are dependent upon physiologic movements that cease at death — the movements therefore, are not seen at autopsy. The valvular meehanisms are not based on guesswork or hypothesis; they are objective findings seen through the bronehoscope. Sueh observations were made already about thirty years ago. Later it was demonstrated that endogenous foreign bodies (exudates — endobronehial, etc., detached tumor tissue, sloughs, sequestra of eartilage, ete.) bring about the same results.

We finally come to a short discussion of so-called ehronic bronchitis — a term often loosely applied at some time or other in the course of some ailment or after a ease of influenza, coryza, allergic rhinitis, ete. with a protraeted eough. In many of sueh eases a diagnosis by exclusion

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could be correct. But this would not necessarily mean that we are without problems in the absence of physical sputumary, x-ray and bronchoscopic study re bronchial and pulmonary disease. Hence our emphasis on protracted and productive cough. We are not probably so interested in the simple mucosal inflammation that is commonly implied in the name "chronic bronchitis", but we do think of the pathologic processes that could masquerade under that term. It should be added that the bronchoscope by contributing exact knowledge of diseased conditions of the living tissues without waiting for autopsy, has proved that this method of procedure is very fundamental to all diagnoses of diseases of the chest, especially combined with laboratory tests and x-ray.

A most interesting aspect is the analysis of 92 consecutive cases reported by Jackson. These patients came with a working diagnosis of chronic bronchitis. Forty had stenosed bronchial conditions; twenty-one had incipient bronchiectasis; four had neoplasms (benign or malignant); seven were T.B. in origin; only twenty had evidence of simple diffused bronchial inflammation (bronchitis). Unquestionably such analysis is worth while remembering.

A review on a conspicuous feature of the bronchoscopic appearances of a diffused chronic bronchitis by the above author stresses the changed characteristics of the secretions. Under normal conditions we generally find some diffused transparent moisture that covers the mucosa with an apparent film; in the inflammatory condition we find the secretions adherent in patches, plaques or droplets that are opaque with whitish or yellow-tinged cloudiness, often greenish. In this stage the mucosa is thickened, reddish and velvety; as the disease advances the mucous membrane is patchy, cicatrical, and branching vessels can be observed. Having ruled out bronchial obstruction and having diagnosed a case of chronic bronchitis do not necessarily mean that we are without problems relating to the early detection and diagnosis of this disease. Why? Because chronic bronchitis is very prevalent in many parts of the world. It is self evident that this type of patient pays little attention to interpretation of symptoms outside of the cough. Where does he go for his cough medicine — until he has four or five bottles of cough mixtures? How does he manage his chest pains if he has any? Who is giving him "cough medicine" and sedatives? More important than the self-medication and the visits to drug stores are the human psychological peculiarities — fear and the dread of consulting a throat surgeon and incurring expense.

As to nontuberculous pulmonary abscess we must remember that the term has been too loosely applied, the literature on the subject so chaotic that a clear analysis of the entire picture is difficult to obtain. Moreover, a clear analysis of statistics is even more confusing. It is believed according to several authors, that the prophylaxis of lung abscess due to obstruction is one field in which treatment through bronchoscopy occupies a position of greatest usefulness, as obviously shown in cases of obstruction due to foreign body (98% of cases in the prevention of suppuration). Restoration of drainage and ventilation by bronchoscopic treatment re-establishes the defensive power of the lungs. In diagnosis, the bronchoscope carries the excellent role of giving us the important clinical information of the living diseased conditions found in the bronchi or lungs. Furthermore, biopsy obtained through bronchoscopic technique furnishes absolute information in most complicated cases.

Also in pulmonary abscess formation we generally obtain the predominant bacteria and such specimens are obtainable with ease, precision and certainty. It is now well known that bronchoscopic treatment in acute pulmonary abscess may not only provide adequate drainage, but will also permit the abscess to go on to simultaneous closure and healing. The most common complications that could ensue in such cases are, of course, the dreaded three conditions — gangrene, bronchiectasis and pneumonitis of the progressive suppurative variety.

As to the conservative bronchoscopic and general treatment in subacute and chronic abscess we have at our command several different but commonsense related procedures. For instance, a favorable diet, a good deal of rest, attention to symptomatic treatment, penicillin or some other antibiotic, sulfa drugs (if favorable as to the patient's blood condition), bronchoscopic aspirations and spraying with a 5% solution of sulfathiazole and, if necessary, transfusions. One of the most important points brought out is the role of bronchoscopy in connection with drainage and ventilation. It is accompanied by frequent

endoscopic aspirations of pus or endogenous sequestra, weekly, biweekly or even oftener if necessary in order to lessen the load of the bronchial cilia. Such treatment may prevent stagnation and other septic processes that could bring about the condition known as bronchiectasis.

Case Report.—About ten years ago, a man, J. B., aged about 39, came to the office complaining of hayfever, nasal and "sinus trouble" — a condition he experienced since a number of years before this consultation with me. He appeared pale, undernourished, underweight, nervous and coughed a good deal. He further complained of pressure in the throat with a constant urge to cough and expectorate. Yes, he was examined by several doctors; he was bronchoscoped by a well-known specialist in one of the clinics and was told to have bronchoscopic aspirations and nothing else. But he was quite restless because of his nasal irritation, sneezing, coughing and constant spitting. A checkup by indirect laryngoscopy and anterior and posterior rhinoscopy revealed only two small polyps extending from the ethmoidal region. He then consented to go to the Hospital for the removal of the polyps and additional study and observation. The blood pressure was syst. 100; diast. 80; pulse 72; temperature normal; hemoglobin 75%; reds 4,440,000; and the whites 8900; Wasserman negative; urinalysis normal as to specific gravity, reaction, sugar, albumin or pus. X-ray of the paranasal sinuses showed evidence of cloudy maxillaries and ethmoidals. The patient refused to have his chest x-rayed at that time — he expected to be called into the army and wanted to see what the army doctors would advise. His polyps were removed and for a while he seemingly improved. He was soon drafted into the army and I believed the case to have been closed.

Several years later, upon release from the army, he returned to my office with complaints of various chest symptoms in addition to his hayfever and cough. After a preliminary nasal and throat examination I advised a checkup as to diet, temporary local nasal treatment and x-ray of his chest and bronchoscopy. He consented but before completely carrying out my advice, he disappeared for a period of about five years. When he again reappeared about two years ago, I insisted that he submit to thorough x-ray examination of his chest and peroral endoscopy which he finally agreed to do.

X-ray report revealed, according to a competent roentgenologist as follows: "The chest shows rather heavy hilar and lung markings. In addition there is a marked emphysema in the lower left lung with flattening of the left dome of the diaphragm. All of these changes are probably due to repeated lowgrade infection. There is a possibility of a bronchiectasis associated with the emphysema in the left lower lung. The heart and aorta are normal."

I advised the patient of his condition and he consented to a laryngoscopic and bronchoscopic examination. Laryngo-tracheo-bronchial tree revealed the following: No distortion or obstruction in the larynx or trachea except a simple chronic inflammatory condition. The left bronchi revealed a typical case of chronic bronchitis with pulmonary suppuration (suspect of lung abscess with bronchiectasis). The patient responded well to bronchoscopic aspiration and sprayings with a solution 5% sodium sulfathiazole. Repeated bronchoscopic aspirations and sprayings at the hospital and office treatments improved his condition to an unbelievable extent. He gained in weight and strength and no longer coughs or feels "cold". His entire demeanor has changed for the better.

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EASIER SAID THAN DONE

Gastroscopic biopsy is not the last word in diagnosis. The procedure locally is traumatizing to a degree and uncomfortable, but seldom painful. There are many technical difficulties. For instance, the biopsy forceps handle and your hand and eye are about a yard apart from the objective. Have you ever tried to pick up a pin from the floor while standing on your head? This is somewhat similar to the sensation I had with the first few biopsies. In spite of these admitted difficulties, one cannot ignore the fact that here is a method whereby tissue from a lesion that can be seen is removed for leisurely study. One must say, therefore, that an objective diagnosis from this tissue is final and is the equal of that of any postmortem or surgical specimen if positive for malignancy or disease. *Paul L. Shallenberger, Advances In Diagnosis Of Gastric Disease. Pennsylvania M.J. Aug. 1952.*

Common Neurosurgical Problems in General Practice

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This presentation deals with five symptoms or symptom complexes frequently met with by the general practitioner. These are headache, epilepsy, sciatica, intractable pain, and infantile hydrocephalus. At times these symptoms indicate the presence of a neurosurgical condition. A knowledge of the possibilities involved is essential for their intelligent investigation and management.

Headache: Headache is one of the most common of human complaints. It may be associated with malformation or disease of any organ or system of the body and is perhaps as often a symptom of physiologic disturbance as of anatomic alteration. Often the physiologic disturbance is secondary to emotional conflict or anxiety.

The principal pain-sensitive structures of the head are the scalp, galea aponeurotica, and fascia and muscles of the head; the periosteum of the skull low in the frontal, temporal, and occipital regions; the dura mater at the base of the skull and around the venous sinuses; and the intercranial arteries. The mechanisms that produce headaches are traction on cerebral veins with displacement of the great venous sinuses, traction on the middle meningeal arteries or the large arteries at the base of the brain, changes in caliber of the intracranial arteries, direct pressure on cervical nerves that carry pain impulses from the head or inflammation in or about the pain-sensitive structures of the head.

It is necessary to determine the location and type of the headache, its mode of onset, duration, and frequency. Headaches may be acute, occasional, or chronic. Chronic headaches may be continuous or recurrent. The acute or the occasional headache need not be considered in detail here. We are concerned with continuous or recurrent headache. All recurrent headaches are not migraine, but the history of recurrent episodes of headache with freedom from discomfort between attacks suggests a physiologic rather than an anatomic disturbance.

Because headache is such a common manifestation of physiologic or anatomic disturbance a legion of conditions have to be considered in differential diagnosis. From a neurologic standpoint, the most important diagnostic categories to consider are cerebral vascular anomalies or disease, migraine, post-traumatic states, increased intracranial pressure and psychogenic headaches. Increased intracranial pressure is the rarest of these but of most interest to the neurologic surgeon.

The headache of increased intracranial pressure is persistent if not continuous. It is usually worse after several hours in the recumbnt position and often awakens the patient in the early morning hours. Nausea and vomiting tend to occur on arising and are usually present when the headache is severe. Vomiting without nausea often occurs and may be forceful (projectile).

Epilepsy: About 500,000 people in the United States are subject to a form of so-called epileptic seizures. This makes epilepsy about as common as tuberculosis. Patients with epilepsy can be classified into those whose seizures have an organic cause in some demonstrable disease or injury of the brain, the symptomatic group and those in which no such cause can be demonstrated, the so-called idiopathic or cryptogenic groups. Organic injury or disease which may produce epileptic seizures includes birth injury as well as cerebral injury at any age; inflammatory lesions such as encephalitis, brain abscess, granulomas; vascular anomalies as angiomas and arteriovenous aneurysms; neoplasms; and the spontaneous cerebral vascular disturbances, such as hemorrhage, thrombosis and embolism.

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The usual clinical classification of convulsive seizures divides them into grand mal, Jacksonian seizures, petit mal, and so-called psychomotor or temporal lobe seizures. Of these the Jacksonian seizure has the greatest significance to the surgeon because it is most often caused by a local irritative lesion. This is a local seizure of some part of the body or even one side without loss of consciousness. The attack may spread to adjacent areas by the "March" of the seizure up or down the motor cortex. Jacksonian seizures usually have an organic cause and the lesion can be accurately localized by the location of the seizure. Consequently, patients presenting this type of attack should be thoroughly studied for possible surgical lesions. It must be kept in mind that the Jacksonian onset of a generalized (grand mal) seizure and a localized sensory seizure have the same diagnostic significance as true Jacksonian seizures.

The age of onset of seizures furnishes some presumptive clue to their cause. Attacks beginning in the first two years of life are usually due to birth injury, cerebral degeneration, or some congenital cerebral defect. If the onset of habitual seizures is in childhood (between two and ten years) an objective course of the seizures can usually be found and is often birth injury, post-natal trauma, cerebral thrombosis during an acute illness, or encephalitis. Convulsions starting during adolescence (second decade of life) are apt to be of the cryptogenic variety, unless secondary to brain injury. When the onset is in youth, that is, between 20 and 35 years of age, cerebral trauma, vascular anomalies, or intracranial tumors are the most important causes. In older adults, between 35 and 55 years of age, the most common causes of onset of epileptiform seizures are cerebral neoplasm, head injury, and arteriosclerosis. After the age of 55 vascular lesions of the brain are the most common cause of seizures but brain tumor is still possible, even in the aged.

All seizures beginning in adult life must be regarded as due to intracranial neoplasm until both meticulous clinical investigation and the passage of time have proven otherwise.

Sciatica: The syndrome of low back pain associated with sciatic pain is a common one. The concept that this could be produced by protrusion or extrusion of a lumbar intervertebral disc is relatively recent but has become firmly established during the past two decades.

This syndrome must be considered a symptom, not a disease, and a thorough search must be made for the cause. It may be produced by skeletal or muscular involvement such as spondylitis or acute and chronic infection. True neuritis of the sciatic nerve is rare but can occur. Intraspinal tumor is also to be thought of especially if there is bilateral sciatic pain. Malignancy of the pelvis, especially carcinoma of the cervix in the female and of the prostate in the male may either metastasize to the lumbar spine or by direct extension involve the lumbosacral plexus.

The history especially as to relation to back strain or sprain is very important. Since pain due to intervertebral disc protrusion is often temporarily relieved by rest, a history of remissions with exacerbation after heavy work or exercise is important. Pain due to irritation or compression of a nerve root has certain characteristics. It is constant in location, usually severe in nature, and is made worse by increase of intraspinal pressure as by coughing, sneezing, or straining. However, the pain of a ruptured intervertebral disc is usually relieved by rest and increased by activity. It may be more severe on sitting than on standing. The pain of spinal cord tumor on the other hand is often worse at night and the patient may get up and walk the floor for relief.

General physical examination with special reference to the back must be carried out. Pelvic and rectal examination must exclude neoplasm arising outside the spine. Roentgenographic examination of the lumbo-sacral spine and pelvis is necessary to reveal primary bone lesions. The Lasegue, Patrick and Naffziger (bilateral jugular compression) signs are important in differentiating nerve root irritation or compression from hip joint disease. Careful neurologic examination is essential. Reflex changes are important. In protrusions of the fifth lumbar intervertebral disc, the Achilles reflex may be impaired or absent. Protrusions of the fourth lumbar disc may also affect the ankle jerk; rarely they affect the knee jerk. Hyperesthesia or hypesthesia to pin prick about the foot must be carefully sought for. Atrophy of the calf muscles and paresis of plantar flexion of the foot is at times associated with fifth lumbar disc protrusions. Paresis of the extensor hallucis longus

and even of dorsi-flexion of the foot may be seen with protrusions of the fourth lumbar disc.

Spinal fluid examination is of great value when intra-spinal neoplasm is suspected. Complete or partial subarachnoid block may be seen and marked elevation of the spinal fluid protein is usually present with tumors of the lumbar spinal canal. Contrast myelography is of great value in recognizing and localizing intra-spinal lesions, especially disc protrusions. However, its accuracy in skilled hands is only about 75 per cent and the percentage of error is much higher if the examiner lacks experience.

Intractable Pain: For the purposes of this discussion, intractable pain may be described as pain constant and severe enough to require the continued use of narcotics for relief and either due to inoperable malignant disease or to some other condition not amenable to direct treatment. These patients unless in the last stages of malignant disease deserve the comfort and relief that an appropriately planned and executed neurosurgical procedure can give them. Pain in the trigeminal distribution, the nasopharynx, the posterior cervical region, or confined to four or less intercostal nerves can be controlled by dorsal root section (rhizotomy). Certain cases of pain in the lower extremities or pelvis, particularly in advanced malignancy may be treated by subarachnoid spinal alcohol injection. This carries considerable risk of motor disability and sphincter disturbance and should be reserved for patients who are already bed-ridden or have a short life expectancy. Intractable pain below the nipple line (fifth thoracic dermatome) can be relieved by antero-lateral cordotomy (spino-thalamic tract section). If the pain is bilateral the cordotomy should be carried out in two stages, a week or more apart and at least two spinal cord segments apart. High cervical cordotomy may be used for high thoracic or upper extremity pain but I prefer medullary tractomy for these patients.

Certain patients with pain of severe nature and especially some with malignant disease have a marked emotional reaction to their condition with fear, anxiety, and tension. Some of these patients react poorly to rhizotomy or cordotomy and are resentful of the resultant sensory loss. Prefrontal lobotomy is a useful procedure for them. They still have pain perception but are relieved of anxiety and tension and usually do not complain spontaneously or ask for narcotics. On the other hand, well adjusted patients with stable personalities who are facing their fate with equanimity should not be subjected to the alternation of personality and behavior which prefrontal lobotomy produces.

Hydrocephalus: Enlargement of the head during infancy is frequently seen. It is usually associated with tenseness or bulging of the fontanelle and prominence of scalp veins. As it progresses the appearance of the child is characteristic with a proportionally large head, small triangular face, prominent forehead and convergence of the eyes. Since any expanding intracranial lesion in the infant will produce enlargement of the head, the possibility of subdural hematoma, neoplasm or even abscess must be considered. Tumor and abscess are rare but infantile subdural hematoma is more common than is generally realized.

It should therefore be emphasized that every infant whose head is noted to be enlarging should have a diagnostic bilateral subdural tap. If a subdural hematoma is not found further investigation should be carried out, specifically, dye and air studies. The former will determine whether a block or obstruction exists in the ventricular system, the latter may reveal the type and location of the causative lesion and also provide a means of evaluating the degree of enlargement of the ventricles and consequent cerebral damage. In the majority of patients the hydrocephalus will be found to be due to some congenital or inflammatory obstruction of the cerebrospinal fluid pathways or to disturbance of the mechanism of absorption of the fluid.

If feasible a direct attack should be made on the cause of the obstruction. Often this is not feasible either because of the nature or location of the lesion. The surgeon has a variety of pallative procedures for either shunting the flow of cerebrospinal fluid around the obstruction or for drainage of the fluid into some other body cavity. These include third ventriculostomy in which an opening is made in the anterior end or floor of the third ventricle to permit escape of the fluid into the basiliar cisterns; ventriculo-cisternal shunt (Torkildsen) with drainage of the fluid from the lateral ventricle through a polythene tube to the posterior cistern; spinal-ureteral or ventriculo-ureteral shunts; ventriculo-antral shunt; and ventriculo-peritoneal

shunt. Each of these have their special advantages and disadvantages; all are palliative and only give temporary relief unless the cause of the hydrocephalus is self-limited or at least non-progressive. Some surgeons have reported success with resection or coagulation of the choroid plexus but this has been associated with a high mortality and given poor results in my hands.

A Review of Some Concepts in Psychiatry

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Psychiatry might broadly be defined as a science of human behavior. As such it is a basic science requisite in the education and in the application to diagnosis and therapy of a patient much as are such sciences as anatomy and physiology. As a specialty among other medical specialties it may be considered that specialty which deals with the disturbing psychological, functional and physical, disease and syndromes or symptoms for which the etiologic elements show a preponderance of causative factors in the psychological sphere.

Concepts concerning etiology of disturbed physical and mental health are expressed in terms of clinical and social medicine seen as integrated and functioning together to give us an understanding of the causative factors in disease. This is distinguished from attempting to find a specific etiology as expressed in Koch's postulates. Causative factors are seen as predisposing, precipitating and perpetuating factors. Such concepts call for an understanding of a patient who comes complaining of headache as including information about the nature, location of the headache, and the presence of post nasal drip suggesting a sinus infection. But it also includes information relative to the nature of the man's employment as a head of a chain store, his feelings about the unfairness in not receiving a bonus from his firm after a transfer which was beneficial to his firm, and the relationship of tenseness and feelings of stiffness in the neck muscles, followed by headache after his ideas have failed of acceptance by the supervisor of his district.

In the study of any disease syndrome or symptom it has been customary to think in terms of tissue alteration. Often, we expect profound pathologic changes in morphology to explain the disturbance of which the patient complains. Certainly demonstrable physiologic alteration is expected when no gross morphologic change exists. Although many conditions associated with such changes are seen it is not uncommon to find patients in whom such profound alteration cannot be demonstrated. Too often, if we continue with the complaint of headache as an example, this may call for an evaluation of eyes, teeth, sinuses, skull, brain, in what is often a fruitless search for pathologic alteration. The search for an explanation in terms of psychopathology may be overlooked. Such psychopathology as extreme hostility and aggression against persons in authority stemming from an earlier repressed hostility toward parents may not be considered as important pathology. Yet such feelings may lead to profound physiologic change with vasoconstriction and subsequent vasoconstrictor headache. In the development of the basic science of psychiatry and the specialty of psychiatry, the science of psychopathology has become as important to an understanding of disease and symp-

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toms as is the science of pathology to an understanding of the breakdown in the homestatic balance of the tissues with morphologic changes of an abnormal character.

The key to an understanding of psychologic disequilibrium or psychopathology is the development of the personality. One should understand the influences of the motivation of the individual, the goal directed activity of the person in seeking the objects and goals which will fulfill his needs, and the many adaptations made in an attempt to solve the problems created by the interferences with such motivationally induces goal directed behavior of the person. Those solutions which are made and remain as more or less specific automatic responses to similar situations encountered later in life are recognized as one of the elements of character traits. All the factors of inherited characteristics plus the automatic adaptive responses give the individual a kind of personality makeup which represents reasonable smooth flowing relationships to people and situations. In a sense it is the complementary aspect of the individual in the psychic sphere to his morphology in the physical sphere of activity. However, these aspects of the person are only completely divisible as a convenience for purposes of study. No such isolation of functioning is in fact possible for the total functioning human being.

These concepts when applied to the patient with headache require that we study, among other elements, his need for mastery of environment as a child: his striving for self assertion against environmental forces which deny him the fulfillment of his goal in aggressive overcoming of obstacles which stand in the way of satisfaction of his needs and desires. A solution is found in a denial of such desires and the development of an ingratiating, pleasing, sometimes obsequious response to authority which gives him partial satisfaction of his needs. This character trait helps him make a "normal" adjustment in the community without symptoms. Under the stress of irritations that awaken his hostile aggressive feeling the individual finds his previous pattern of behavior ineffective in controlling the aggressive impulses. A new adaptation occurs in the nature of physiological changes associated with a symptom, headache, which acts to solve the problem, but at a new sacrifice which is uncomfortable to the patient and for which he seeks relief.

Just as a descriptive classification of headaches as vasoconstrictor, vasodilator, etc., succeeds only in making a descriptive categorization which may be helpful in an understanding of and treatment of the patient, so the previous concern over classification of patients as psychoneuroses, psychotic, psychopathic personality, etc., had, and still has considerable measure of value. Nevertheless a more dynamic understanding of the forces and adaptive reaction in the individual and environment which contribute to the clinical picture will be more rewarding in the diagnosis, prognosis and treatment of the problems of the patient.

The primary emphasis in seeking a relationship between disease or syndrome, and treatment which is characteristic of disturbances in which a specific bacterial organism creates somewhat specific morphologic changes (pathology) epitomized by such clinical entities as pneumonia. Unfortunately such relative specificity between stress (an invading organism) morphologic change (pathology) and treatment has not been realized for the majority of individuals who seek help for symptoms which are disturbing to them.

The physician is familiar with the use of drugs which alter the invaders of the body to weaken them or alter the body to resist the invaders, or bring about such alterations in the tissues, chemical, psychological or structural, which help healing or alleviate pain, suffering or discomfort. He frequently fails to realize that his chief therapeutic weapon is the patient-physician relationship and what it means to the patient. The patient endows the physician with the healing qualities that a child attributes to his parent. This relationship must be studied and become as nearly a scientific tool as it can be made by each physician according to his personality, training and ever developing insight. Treatment, therefore, should not only include such therapies as mentioned above but also an awareness that improvement in the patient may have occurred because of the fact that the patient was able to benefit from having been able to express his feelings of having been unfairly treated by the supervisor and the hostility he felt at such treatment, in the non-condemning atmosphere of the physician's office.

Essentially I have tried to summarize some

very important concepts of the place of psychiatry in understanding the patient who comes to your office often with what seems an obscure basis for his difficulty. I feel that in furthering one's acquaintance with these concepts one may be able to make the obscure more transparent. Concepts and methodology somewhat different from those you customarily use may have to be introduced.

What Does the Lung Do Besides Breathing?

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Dr. Max Samter, Associate Professor of Medicine: Time was when physiology was simple. The stomach used to be an organ of digestion, the kidney of excretion and the lung of respiration. Now, the stomach appears to participate in blood formation, the kidney maintains the ph, and the lung has so many intriguing aspects that it has become desirable to devote an entire seminar to its functions besides respiration. Dr. Sadove will open the symposium and discuss the lung as a secretory organ. Dr. Hick will review its role in heat regulation and water exchange; Dr. Whitehorn its hemodynamics; Dr. Kark its effect on the destruction and production of the elements of blood and its enzymes; and Dr. Jackson its function in allergy and immunology.

Dr. Max S. Sadove: Pulmonary secretion which originates in the alveolar ducts undergoes continuous change as it moves toward the trachea. Inflammatory secretions are thick and viscoid at the site of origin. They are high in nitrogen, ash and chlorides. During the passage through the bronchial tree they become less viscoid and decrease in mineral content. Obviously, therefore, the lung must be able to digest and reabsorb at least part of this secretion.

Many factors participate in the final structure of the secretions. Dr. Poncher and Dr. Holinger conducted a series of studies which showed that oxygen thickens the secretions and blanches the bronchial mucous membranes. They concluded that oxygen should be used with caution in inflammatory pulmonary disease, in which secretions, not anoxia, are the main problem. Steam on the other hand, increases the amount of bronchial secretion, decreases viscosity and does not produce a blanching of the mucosa. Contrary to popular belief, cold water sprayed by a jet-type nebulizer would probably be even more effective than steam. Water is a very important and frequently neglected part of the regime of production of thin, easily expectorated secretions. If a patient is dehydrated, no expectorant drugs can be expected to work efficiently. The therapeutic effect of carbon dioxide has been highly over-rated for resuscitation purposes in that most patients have excess CO_2. I usually teach my students that the best place for it is in the tank from which it comes. In small concentrations, however, it thins secretions, may increase their

ash content and cause hyperemia of the bronchial mucosa. Iodides, ammonium chloride, and most other expectorants thin secretions and increase their quantity. Interestingly enough, nobody seems to be certain how expectorants work.

Dr. S. Howard Armstrong, Jr., Professor of Medicine: The action of the iodides is rather complex. Apparently they diminish some intermolecular forces that hold long chain biological molecules together in bundles. This effect is well illustrated by the effect of iodides on the formation of fibrin from fibrinogen. However, they have this effect only in concentrations which are far beyond those used in therapy. Why the small amount of iodides given to patients with, let us say, bronchial asthma, should have any effect at all is rather mysterious. The change in ash contents, by the way, is probably incidental, while the viscosity is the factor which is clinically important.

Dr. Meyer R. Lichtenstein, Clinical Assistant Professor of Medicine: It might be worth mentioning that the use of iodine compounds in tuberculosis is no longer considered the danger that it once was.

A Physician: I wonder why iodinated antibiotics permeate the lungs so well.

Dr. Harry F. Dowling, Professor of Medicine: The problem is now under study — the answer is not known at this time. Clinically it is still questionable whether preparations of iodized penicillin which are now available have a great advantage over those which are now in general use.

Dr. Robert M. Kark: Can you reduce viscosity by spraying proteolytic enzymes into the bronchial tree?

Dr. Sadove: So far the literature is confusing and inconclusive about this point. Theoretically one should expect that streptokinase, streptodornase, and trypsin might be good adjuvants in mucolytic therapy.

Dr. Ford K. Hick: When we inspire, air is warmed and moistened chiefly in the nasal passages before it reaches the lungs where it is at true body temperature. In expiration there is some cooling of the expired air and slight condensation of its moisture on the mucous surfaces as it comes near the orifice. Expired air is almost at body temperature and almost saturated. Observations on animals having a tracheotomy show that respiratory changes in air temperature are chiefly the function of the upper air passages. This function would prevent injury to the lungs in severe cold. A typical temperature value for expired air might be 32°C. The quantity of water lost in expired air per day varies greatly but is of significance. Rubner in 1902 reported a healthy man in comfortable environment lost up to 408 grams of water in 24 hours, exceeding the quantity of insensible perspiration. More recent measurements show the moisture lost from the respiratory passages to be 10-16 grams per hour or about 1/5 to 1/3 the insensible water loss. The total heat loss by warming room air and evaporating moisture is much less than that lost through the skin and for comfortable environments is probably 5 to 8% of the body's heat loss.

Man does not have the means of losing heat which a dog uses in hyperventilation. A dog exposed to heat breathes very rapidly and evaporates from the pharynx and tongue. An interesting paper (Studies in the Physiology of Exercise: Acid-Base Changes in the Serum of Exercised Dogs. H. A. Rice & A. H. Steinhaur, Am. J. Physiol., 96:529, 1931) reveals that even dogs do not do this perfectly and shows that in heat exercise induces alkalosis.

Dr. Kark: What effect does altitude have on these regulations?

Dr. Hick: I cannot answer your question. I do not believe that any work has been published on this subject.

Dr. William V. Whitehorn: It is very difficult to obtain accurate information about the pulmonary blood flow. Consequently, my remarks are at least in part speculative. The following facts, however, have been well documented:

1. The pulmonary circulation is located between the right and left ventricle. Actually the pulmonary bed contains two circulations; namely, the pulmonary and the bronchial circulations.
2. It is a low pressure system with a pressure between 20 to 25 milimeters of mercury for a systolic and 10 milimeters of mercury diastolic.
3. Because the blood flow in the pulmonic circulation must equal that of the systemic circulation, it must be a low resistance system. 15% of the total blood volume may reside in the pulmonary circulation.

4. We know that the system is markedly distensible. It is possible, therefore, to increase blood volume markedly without increased pulmonary pressure. We also know that vasomotor control has only a minor influence, and that the only effective controls of pulmonary blood flow are the outputs of the right and left ventricle and changes in intrathoracic pressure.
5. Oxygen and carbon dioxide concentrations exert local effect on lung tissue, probably direct action on pulmonary vessels.

Dr. Armstrong: How do you explain the vasoconstriction which occurs after occlusion of pulmonary vessels, for instance, following pulmonary infection?

Dr. Whitehorn: I agree that this might be the result of a reflex spasm, even if under physiological conditions vasomotor reflexes play only an insignificant part in the regulation of blood flow.

Dr. Samter: Considering the number of variables which you have mentioned, how can you possibly measure pulmonary circulation in man?

Dr. Whitehorn: You can't.

Dr. Hick: If the capacity of the pulmonary vascular bed varies, as you say, I wonder what controls it. In the skin I know at least of one factor which causes a shift in blood distribution: the increase in temperature and humidity in the environment.

Dr. Robert L. Grissom, Assistant Professor of Medicine: In enlarging Dr. Hick's question, I would like to ask Dr. Whitehorn whether the pulmonary circulation participates in the heat exchange carried out by the lungs.

Dr. Whitehorn: I believe that Dr. Grissom is correct in assuming that heat exchange is a function of pulmonary circulation but, Dr. Hick, I am unable to state how it is controlled.

Dr. Kark: Dr. Hoyle, in his book on "The Nature of the Universe," states that he knows that stars are breaking up and that the universe is expanding, but he knows neither why this happens nor the way in which it is accomplished. I know of four instances, apparently non-correlated, in which the lungs participate in production or destruction of enzymes and of formed elements of the blood. How or why this happens in the lung are mysteries.

1. The lung manufactures pro-plasmin (plasminogen), the proenzyme of plasmin which lyses clots. It is now generally believed that uncontrolled hemorrhage after shock is caused by the production and release of proplasmin from the lungs.
2. The lungs destroy prothrombin. Interestingly enough, this has been known for a long time. It explains in a rational way the rare instances of hemorrhagic diathesis seen in patients undergoing fever therapy. Fever produced hyperventilation and perhaps this caused increased destruction of prothrombin with a fall to dangerously low levels in the blood.
3. Bierman showed that the lung filters white blood cells out of the circulation. In fact, if blood of patients ill with myeloid leukemia is injected into non-leukemic recipients, the transfused white cells will be removed during one cycle of blood through the lungs.
4. The lung contains megakaryocytes and manufactures platelets. Howell has contributed experimental evidence for the pulmonary manufacture of platelets in animals. One must add, however, that it is still questionable whether the same mechanism exists in men.

Dr. George G. Jackson: While it is undisputed that the lung plays an important part in immunology, only some of its functions have been clarified in controlled experiments. I would like to list rather than discuss a number of facts which have been established:

1. Inorganic, organic or bacterial antigens reach the lung easily by inhalation.
2. The lung has large absorptive surfaces. Antigens, therefore, can enter the blood stream easily. It is known, for instance, that polypeptides can be absorbed easily from the alveolar membrane.
3. Lymphatic tissue is abundant in the lungs. It is known that young lymphocytes (and perhaps plasma cells) can release neutralizing antibodies.
4. To talk specifically of bacterial invasion: mucin, which was discussed by Dr. Sadove, has been shown to increase the virulence of certain microorganisms by inhibiting phagocytosis and by increasing the susceptibility of the host; thus mucin causes harm in the presence of bacterial infection. Since mucin, on the other hand, is able

to prevent hemagglutination of red blood cells by influenza virus, it may serve a useful purpose in the presence of virus disease of the lungs.

5. A biological substance, spermin, which has been found to be highly destructive to tubercle bacilli *in vitro*, may be present in lung tissue.

Dr. Samter: One might add that antibodies of the anaphylactic type, wherever they may be manufactured, are deposited in the lungs, at least in guinea pigs and men. Warren and Dixon sensitized guinea pigs to globulin which had been iodized with I^{131}. Immediately after the first injection most of the radioactive material appears in the liver. However, if the radioactive globulin is injected into sensitized animals for a period of two weeks, most of it is found in the lungs, apparently trapped by the antibodies in peribronchial tissue.

Dr. Grissom: Dr. Sadove's and Dr. Jackson's remarks about mucus make me wonder whether blocking agents like hexamethonium, which are likely to diminish secretion of mucus, will have a beneficial or an adverse effect on the mucous membranes.

Dr. Samter: It seems that we know relatively little of the factors which control respiratory disease. A few days ago I talked with Dr. I. Davidsohn about the subject of "susceptibility." Dr. Davidsohn feels that some instances of the so-called common cold might be due to the activation during inclement weather of cold agglutinins which are present in the mucous membranes of the respiratory tract — a thought which had never occurred to me. This, of course, is only one way of saying how much we have yet to learn.

Medical Education for General Practice

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Medical education can be divided into the period of undergraduate study and into a less sharply defined postgraduate period of training. Actually, medical education starts in the liberal arts college and continues throughout the professional life of the doctor. The primary responsibility of the medical school is to provide the proper environment in which the student, guided by his instructors, is gaining a thorough knowledge of the structure and function of the human body, while achieving an understanding of the life processes in health and disease, and particularly in getting an orientation toward the role of the physician in society. It is in the medical school that the future physician should have full opportunity to develop the habits of study, critical observation, intellectual curiosity and genuine interest in the welfare of his patients. In the last analysis, the medical schools are responsible to the public for the kind of product they turn out.

The question that occurs to the medical educator is whether there should be special schools for general practitioners, others for surgeons, and still others for the various specialists now identified. It is our belief that the answer to this should be a clear-cut "No". There is evidence at the present time that student preference for general practice is on the increase and that many schools and teaching hospitals have reevaluated their curricula and have programs of training which dignify general practice. Specialization should come only after an adequate background of training in fundamentals. The fundamental contribution of all undergraduate schools is to supply the concepts, stimulate

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the interests, give the integration, and achieve the training for social responsibility that is the basis on which further advances may be built. Medical schools must offer an orientation toward the facts and skills of medical science that goes beyond the mere training of super technicians. They must rather produce physicians who are wise in the application of their knowledge as well as skillful in its use.

The main function of the medical profession is to heal, relieve and comfort those who are sick or in distress. This, in the broadest sense, must be based on a satisfactory kind of understanding of the physical and social conditions surrounding these unhappy individuals. Usually the general practitioner, with his understanding of family background, is more likely than the speciaist to be able to develop the strong personal bond in the physician-patient relationship that will allow for full range of the doctor's contribution. The treatment of a disease may be entirely impersonal, but the care of a patient should and must be completely personal. We have the responsibility to see that our faculties, practically all of whom are specialists, do not stress too much their own intense interests in a narrow field but present rather the fundamentals underlying all specialization. This same caution must be applied to the so-called preclinical fields. We must achieve a sufficiently strong unification which cannot be overbalanced or masked completely by later training in restricted areas. We must emphasize the basic training fundamentals both for general practice and specialization. We must help change the attitude of the public toward the contribution of the well-trained practitioner, for this is a crucial factor in determining his status. We must reeducate the public while we are educating the students in the position of dignity and respect which should be accorded to the family physician because of the necessity of his function and the value of his services to the general public.

At the Chicago Medical School we are endeavoring to supply the kind of education that should serve as the basis for general practice as well as later specialization. We try to achieve integration by introducing the student from his very first day in school to the problems of clinical medicine and the application of his basic science knowledge to the healing of the sick. During the entire freshman year the students regularly have a "correlative symposium" which shows them exactly how the knowledge and discoveries in anatomy, physiology, biochemistry, etc. are applied to the clinical problems and contribute to the care and understanding of patients and disease. This effort also shows the students how clinical studies and problems may influence the advances in the basic sciences. The training offered by the department of psychiatry throughout the freshman year serves to direct the students toward an understanding of the emotional, environmental, economic and social factors that distinguish a "patient" from a "disease" and an "individual" from a "case". In both the freshman and sophomore years a series of lectures and demonstrations with patients serves as an "Introduction to Clinical Medicine" and allows for greater integration with the basic sciences as well as pre-viewing the work of the clinical years. In these latter, intimate first-hand contact with patients, both in a large charity hospital and in a private community hospital is the order of the day.

We have for some years at the Chicago Medical School had a twelve-month sophomore year and a twelve-month junior year in addition to the usual nine-month freshman and senior years. This extra time has made possible a broadening of the program so that in addition to the extensive ward and dispensary clerkships, the students may receive sufficient instruction in the basic principles of each of the specialties so that an acquaintance and an understanding in both depth and breadth can be achieved. To prepare the student for the treatment of the whole man is the aim of medical education. Time is necessary to achieve this end. We have organized our dispensary into the usual general and specialty clinics but we also have an "admittance clinic" where all patients are first seen by a diagnostic team consisting of internists and psychiatrists. This is one of our most academically profitable teaching clinics and emphasizes to the students the necessity of considering the patient as a total human being in this complex social and physical world. The student is trained to understand as many factors as possible about these patients, some of whom will need hospitalization while others may be helped and reassured with the clinic visits alone.

Some schools have adopted extensive preceptorships where students are sent out for varying periods of time into the community to serve with a practicing physician. While the aims of such programs are good and much beneficial training may result from them, they are not without possible detrimental effects. There is no doubt that close individual contact with a good physician and teacher can be a most effective teaching method. The danger in the widespread use of preceptorships lies in the difficulties of selection and securing of the right kind of men for this job. Much time may be wasted by students and harmful habits learned if their preceptor is not of the very highest caliber, both personally and professionally. There is also inherent in this system the possibility of exploitation of the student for rendering service not associated with any real learning opportunity. We feel that the best results can be achieved if we concentrate our energies on supplying the best possible faculty at the school and affiliated hospitals. We believe it is not necessary to use the preceptor system if care is exercised to supply the right kind of teachers, vitally interested in serving in a responsible fashion the academic needs of the school. We have achieved this in part through the extensive use of full-time clinical teachers whose entire energies and interests are devoted to the goal of medical education and the advancement of medical science. In our school and hospital program we emphasize the personal nature of medical care and the full consideration of the patient as a sick human being seeking help from the physician. We also have on our staff many successful private practitioners who have a genuine interest in teaching and who make a voluntary contribution of much time and effort to the work of the school. A blending on the school staff of full-time academic men in both the clinical and preclinical areas with the private practitioners of wide experience enables us to give our students a well-rounded medical concept and a broad competent and thorough training preparatory to the general practice of medicine or further specialty training. This plan of instruction is eminently suited to the task of achieving a clear, organized, comprehensive idea of the general body of medical knowledge, skill and responsibility. We believe the student cannot learn all there is to know about medicine in his years in school and that it is our task to prepare him effectively to have both desire and urge to continue his education throughout his professional life. If the student can achieve intellectual and emotional maturity along with the basic principles and knowledge of the various techniques necessary for medical skill during his school years, we will be fully repaid for our efforts.

The field of medicine is so broad that the casual postgraduate training of a general practitioner must be inadequate in at least some and probably all specialties. General practice varies considerably from one community to another with respect to the availability or proximity of specialty help. There are, however, what with improved means of transportation and extended hospital and clinic facilities, few communities which will not have access to surgeons and obstetricians in the future. These fields, (surgery in particular), often require such highly specialized techniques that they should be deemphasized in the postgraduate training of the general practitioner in favor of greater emphasis on internal medicine, pediatrics, and psychiatry. Training in psychiatry for the general practitioner should stress environmental factors and should be limited to the simple basic concepts of neuroses with special reference to psychiatric problems in the presence of organic disease and somatic responses to emotional stress. A relatively small amount of training in emergency surgery and general principles of modern surgery designed to equip the general practitioner to handle accidents, until the patient can have the benefits of specialty care, is desirable. For the really well trained practitioner a general knowledge of the various specialties and his own limitations in these areas is essential. Formal postgraduate training of the general practitioner should be at least as extensive as the training of most specialists and should, extend for three years past the internship. This period should be devoted primarily to internal medicine, psychiatry, pediatrics, obstetrics and to head and neck specialties. A special Board should be established for certification of "general specialists" in the field of general practice.

Beyond the formal period of medical school and hospital house-officership, the opportunities for advancing of the general practitioner are today often rather haphazard and sketchy. In

many areas he must still depend largely on his own initiative. It is high time that a more orderly, responsible and rational program of further training for general practitioners be worked out. There exist at present competing efforts to serve the general practitioner which often only lull him into a false sense of advancement. There should be rather a unification of efforts that will allow supplementing the more formal educational experiences of school and hospital. These various efforts should complement each other rather than try to compete with or outdo each other in gaining the attention of the busy practitioner. The general practitioner by the very nature of his work needs an unusually broad knowledge of medicine and is often so busy and so removed from training centers that further advancement is difficult. In some communities the general practitioners are still practicing much the same medicine they learned in their student days. Real efforts must be made to put the general practitioner who is not connected with a medical center in better touch with advancing science. The medical schools are more than willing to contribute in this effort, but they must do so only insofar as they do not sacrifice their undergraduate programs. The serious efforts made over the last twenty-five years by some universities and state medical societies and other groups to bring the best current techniques and advancements to the doctor in his own community have yielded some good results so far as they have gone. Much study and effort is still necessary, however, to provide efficiently more systematic postgraduate training for general practitioners.

Recent wide-spread study in mass education techniques can easily be applied to the continuing education of the physician. Through the coordinated use of local instructors, movies, live television over extensive closed systems or through open telecasts, and the use of television recordings, significant advances in communication and teaching techniques have been achieved. In many instances television instruction not only brought in new avenues of learning but actually were found to be better than teaching by local instructors. In a recent study by the Navy half of the students learned more through televised demonstrations than through actual contact with the teacher. The television camera can visualize the field of an operation, for instance, to a large number of observers all of whom get a better view than even the assistants to the surgeon at the actual site of the operation. In telecasts the teaching efforts do not necessarily have to be limited geographically. And since large areas can be served there is a greater opportunity of securing the services of some of the best teachers in a given field. Clinical conferences may even be held with participants stationed in different parts of the country. One is staggered by the magnitude of the opportunities that may be offered through the medium of colored television.

The attitude of the public toward the general practitioner will depend to a large extent on the actual value it receives from him. This attitude can be profoundly influenced by the educational efforts of the schools and the medical profession both on the general practitioner himself and on the public which assigns him his place in society. The opportunity before us is both challenging and inspiring. We must not fail.

Pathophysiology of Jaundice

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Jaundice is not a disease but a symptom. It is due to an excess accumulation of bilirubin in the blood, body fluids, and tissues, which is responsible for the visible yellow discoloration of the skin and mucous membranes.

It is worthwhile to remember that occasionally a diet rich in carrots may give the skin and serum a peculiar yellow tinge (carotinemia) and that atabrin and picric acid, the latter sometimes used by malingerers, may produce a pseudoicterus. In these conditions, the concentration of bilirubin in the blood is normal, and there is no deviation in the bile pigment metabolism.

In order to understand the mechanisms leading to an excess accumulation of bilirubin in the blood, a brief review of the normal bile pigment metabolism is necessary. Although all phases of this metabolism are not completely understood, some basic facts are accepted as being useful in clinical considerations.

Bilirubin is an iron-free waste product of hemoglobin, derived from aging and disintegrating red blood cells. It is formed by the cells of the bone marrow, spleen, and other reticuloendothelial tissues. Released into the circulation, bilirubin becomes attached to an alpha globulin of the serum, and is present in the normal blood in a concentration of 0.8 to 1.20 mg. per cent. As a waste product without useful function in the economy of the body, it is excreted by the liver into the biliary system, and then into the duodenum.

It was demonstrated by Van den Bergh that bilirubin normally present in the blood, because of its attachment to a protein molecule, does not react with the diazo reagent unless alcohol is added. This bilirubin was named, therefore, the *indirect reacting bilirubin.* Due to its complex molecular structure, it cannot pass the glomerular filter, is never found in the urine, and diffuses into the tissues only with difficulty. Brought to the liver, it is removed from the blood by the parenchymal cells in the manner of a threshold substance, and excreted into the biliary capillaries. During this passage, the chemical character of the pigment is changed by a mechanism whose nature is not completely understood. Whether the bilirubin is split away from the protein molecule, or whether a new, even more complicated compound, a sodium bilirubinate with a loosely attached protein molecule is formed, is not definitely known. The end effect, however, is that the bilirubin excreted by the liver cells into the bile reacts with the diazo reagent without addition of alcohol. This is the so-called *direct reacting bilirubin.* The direct bilirubin has the ability to pass the kidney filter and diffuse easily into the tissues. It is present only in minimal amount in the blood, and a level above 0.2 mg.% signifies liver disturbance.

The bilirubin excreted into the intestine is reduced to urobilinogen by bacterial action. A part of this urobilinogen is oxidized to coprobilinogen and coprobilin, and is excreted in the stool as the coloring matter of the feces; the rest is subjected to the entero-hepatic circulation, reabsorbed by the intestines, and carried back to the liver by the portal circulation. Most of this urobilinogen is re-excreted or reutilized by the parenchymal cells of the liver in an unknown fashion. A small amount escapes into the general circulation, and, being a derivative of the direct bilirubin, is eliminated freely by the kidney.

Under normal circumstances, the stool does not contain bilirubin. Only in severe diarrheas, or after sterilization of the bowel by oral antibiotics, may bilirubin appear in the feces.

The formation and excretion of bilirubin is

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Presented at the Postgraduate Conference, Dixon, Ill., April 17, 1952.

a never-ending process, and the factors controlling it have to be in perfect balance in order to avoid an excess accumulation of the pigment in the blood.

There are several known pathological mechanisms which may interfere with the normal pigment metabolism, and produce icterus. They may operate *before, in,* and *behind* the liver cells. These mechanisms are:

1. Bilirubin becomes a high threshold substance.
2. Excess formation of bilirubin, and inability of the normal liver cells to excrete it as rapidly as it is formed.
3. Mechanical blockage of the bile flow into the duodenum.
4. Disarrangement and damage to the liver cells with impairment of the uptake and excretion of bilirubin.
5. A combination of any of the above-mentioned mechanisms.

The first mechanism has been found to be operating in some relatively rare cases of a congenital condition known as familial nonhemolytic icterus, or constitutional hyperbilirubinemia. This type of bilirubinemia is believed to be due to a disfunction in the liver excretory threshold for bilirubin, and not to a damage of the liver cells. The individuals with this type of disturbance are in good health. Their livers and spleens are not enlarged, and there is no evidence of hemolysis. The bilirubin in the blood is of the indirect type. There is no bilirubin in the urine, and the urobilinogen in the stool and urine is normal.

It may be important to differentiate this condition from a hyperbilirubinemia persisting in some cases of infectious and toxic hepatitis, even after clinical recovery.

Overproduction of bilirubin, in most cases due to an excessive breakdown of erythrocytes, is a very common mechanism of icterus. There is a great variety of causes for a severe hemolysis: protozoa (malaria, Oroya fever); bacteria (Bacillus welchii, streptococcus hemolyticus, or viridans); chemical agents (phenylhydrazine, phenol, benzin, arsenic, lead, gold, etc.); allergy (favism, sensitivity to sulfa drugs); hemolysis of the immune body type reaction (erythroblastosis, paroxysmal hemoglobinuria, mismatched transfusion); hemolysis due to congenital defects of the red blood cells (familial hemolytic icterus, sickle cell anemia, Cooley's anemia); hemolysis in infarcts and hematomas; and finally, hemolysis produced by unknown mechanisms (icterus neonatorum, pernicious anemia, Hodgkins disease, leukemias, carcinomatosis, etc.). In all of these conditions, the liver is not able to dispose of the increased amount of bilirubin as rapidly as it is formed. Excess indirect bilirubin accumulates in the circulation. The large amount of bilirubin excreted into the intestine leads to the formation of great quantities of uro- and stercobilinogen, with a consequent darkening of the stool. At the same time, more urobilinogen is subjected to the entero-hepatic circulation, and a large fraction of it bypasses the liver cells, enters the circulation, and appears in the urine. The bilirubin present in the blood, being of the indirect type, is not excreted by the kidney, and is not found in the urine. Because of the difficulties in diffusion, the discoloration of the skin and mucous membranes is light, and the icterus mild. The increased amount of bilirubin in the bile favors stone formation in chronic hemolytic anemias.

Mechanical blockage of the bile flow, another common mechanism in production of icterus, may be due to extra- and intrahepatic factors. The extrahepatic obstruction may be complete (mostly produced by malignant lesions), or incomplete (due to the passage or to a shifting common duct stone, to strictures, or to inflammation of the bile ducts). Intrahepatic obstruction occurs in some phases of hepatitis, and produces the same type of deviation in the pigment metabolism as the extrahepatic obstruction. Bilirubin in these conditions is formed and excreted by the liver cells at a normal rate. Because of the obstruction, bile cannot enter the intestine, and accumulates in the biliary system.

The increased back pressure damages the biliary capillaries, direct bilirubin escapes into the periportal spaces, and enters the general circulation via the lymphatics. Excess direct bilirubin accumulates in the blood, and, being able to pass the kidney filter, appears in the urine, staining it deeply. As no bile enters the intestine, no urobilinogen or coprobilinogen is formed, and none of it appears in the urine. The stool is light and clay-colored. Bilirubin from the blood diffuses easily into the subcutis and submucosa in these conditions, and the

jaundice is, therefore, very pronounced. In incomplete, or malignant obstruction, the mentioned findings become prominent and irreversible. In benign obstructions, periods of complete or almost complete blockage alternate with periods of release. Correspondingly, there are alternating changes in the amount of bilirubin and urobilinogen in the blood, urine, and stool.

The inability of the liver cell to take up and excrete bilirubin is a further mechanism in formation of jaundice. This type of jaundice is usually accompanied by an impairment of other important functions of the liver, and is due to damage and disarrangement of the liver cells. A great variety of agents are capable of producing these structural changes: toxic substances like chloroform, chlorinated hydrocarbons, cinchophen, etc.; and infections, of which those due to the viruses of yellow fever, infectious, and hemologous serum hepatitis, are the most important.

The deviation of the pigment metabolism in these conditions is as follows: The indirect bilirubin, being formed in normal amounts, is taken up by the healthy liver cells and excreted as direct bilirubin. Part of this bilirubin reaches the intestine and is converted to uro- and coprobilinogen. Another part of the bilirubin, because of the disruption or damage to some liver cells, re-enters the general circulation via the sinusoids. Direct and indirect bilirubin are now present in the blood, and their relative amounts are determined by the degree of the liver damage produced by the acting agent. This agent may occasionally produce hemolysis, or in some phases of the disease, so severely damage the liver cells, that they are not even able to take up the normal amount of indirect bilirubin. The indirect bilirubin will increase in the blood to high levels. The direct bilirubin present in the circulation passes the kidney filter, and is excreted in the urine. The returned urobilinogen is not re-utilized by the damaged liver cells; it escapes into the circulation, and appears in the urine.

In some cases of hepatitis, especially in those produced by the viruses, a characteristic pathological feature of the disease — the periportal inflammatory reaction — may be severe enough to obstruct the intrahepatic biliary capillaries. The deviation of the pigment metabolism in these cases will have the same characteristics as in extrahepatic obstructive jaundice.

Considering the mechanisms producing jaundice from a pathologic-anatomical point of view, it is obvious that most of them may operate in pure form for only a brief period of time. Anemia in hemolysis, back pressure in extrahepatic jaundice, and toxemias in hepatitis may change the characteristics of the primary mechanism very quickly. Therefore, only a careful history with regard to a possible contact with a hepatotoxic agent, a sensible interpretation of symptoms, repeated studies of bilirubin in the blood and urine, and of urobilinogen in the urine and stool, a critical evaluation of liver function tests, and, occasionally, a liver biopsy, will help us to make a correct diagnosis in about 80 percent of the cases of jaundice.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Fatty Inguinal Hernia

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Fatty inguinal hernia simulating indirect inguinal hernia is uncommon. The literature reports only two cases of fatty inguinal hernias during the last twenty years. Lillie & Waugh[1] reported one case of a unilateral fatty inguinal hernia and the senior authors[2] have recently reported a case of bilateral fatty inguinal hernias.

It is fairly common to find small fatty masses during surgery for indirect inguinal hernia. Our findings of small fatty masses approximate the same percentage as reported by Dr. Speed[3], who found fatty masses in 47.4% of his cases.

The fatty inguinal hernia masses may arise either from the preperitoneal fat or may descend with the testes; may be lobulated and covered with a peritoneal-like sac and receive their blood supply from above, or the masses may be broad originating behind the cord at the internal ring and bulge out along the posterior aspect of the cord.

Although Watson[4] stated that fatty hernias do not change in size, are irreducible and do not transmit an impulse on coughing, in our cases we have found that these fatty hernias may increase in size, are reducible and produce an impulse on coughing.

We wish to present a case of a unilateral fatty inguinal hernia simulating an indirect inguinal hernia associated with a hydrocele of the cord.

Mr. D. L. age 39, was admitted to our ward stating that he had a "rupture on the left side for a long time". There had been no pain or obstructive symptoms.

Examination revealed an obese male with a normal temperature, pulse and respiratory rate. His blood pressure was 108/78. An irreducible mass about 7 cms. in diameter was present in the left scrotal sac. This mass was cystic and not tender. The left testicle was not palpable. Examination of the left external ring revealed a firm mass which was believed to be an indirect inguinal hernia. The right inguinal region was negative. A diagnosis of a left inguinal hernia and a left hydrocele of the cord was made and surgery advised.

A left inguinal incision was made, the aponeurosis of the external oblique muscle opened and the cord isolated. A hydrocele of the cord was found and removed. Proximal to the hydrocele a fatty mass measuring about 5 x 2 cms. was found attached to the cord structures and projecting somewhat beyond the external ring. The proximal portion of this fatty mass was in continuity with the retroperitoneal fat. There was no evidence of a peritoneal covering of this fat mass. The fat mass was separated from the cord structures and a high ligation done. Further investigation failed to show any evidence of an indirect inguinal hernia. A Ferguson repair was then done.

The patient made an uneventful recovery.

CONCLUSION

Fatty inguinal hernias are rare and must be considered in the differential diagnosis of indirect inguinal hernia. They simulate indirect inguinal hernia in that they may increase in size, can be reduced and transmit an impulse on coughing.

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POLYPS OF THE G-I TRACT

The management of isolated polyps when found by x-ray examination has many pitfalls. Confirmatory x-ray examinations are always insisted upon before surgery. The bowel is then prepared by chemotherapeutic or antibiotic agents following thorough saline cleansing. The use of terramycin per os for 48 hours after purging has proved adequate. Transcolonic excision may then be carried out with safety in most instances. Exact localization of the polyp after opening the abdomen may be a problem. With a clean bowel, palpation between the flattened fingers should be sufficient but in an obese individual with tense epiploic appendages, this may be hopelessly inadequate. The Cameron light is of assistance in canvassing the bowel by transillumination. Colotomy in the general region indicated by the x-ray films may be indicated and justifiable. It is my custom also, because of the frequent finding of adjacent polyps to have a sterile sigmoidoscope available to explore transabdominally the adjoining segments of bowel. With pedunculated polyps, simple excision within the lumen is sufficient. With a sessile lesion or a thickened pedicle, wedge resection may be preferable. Where multiple polyps are found closely associated, a sleeve resection and end-to-end anastomosis is recommended. *Herbert M. Giffin, M.D., Polyps Of The Gastrointestinal Tract. Med. Ann. District of Columbia, Oct. 1952.*

CASE REPORTS



Unusual Postoperative Ventral Hernia

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Mrs. E. D., a housewife 59 years of age and weighing 160 pounds entered Holy Cross Hospital August 17, 1951 complaining of pain in the lower abdomen and frequent vomiting in the preceding 24 hours. She had a midline hernia protruding above a pendulous obese abdomen. She had attempted, unsuccessfully and repeatedly to reduce the hernia in the past 24 hours. She had a bowel movement shortly before the hernial content became strangulated but not thereafter. The patient was not especially concerned, at first, about her inability to reduce the hernia. She had had it for 14 years and had often replaced the hernial content into the abdomen. It was only after she developed abdominal pain and vomiting that she called a physician.

The surgical history of this patient is pertinent to her condition in her most recent hospitalization. At the age of 21 years she had an appendectomy performed through a right rectus incision. Her recovery was rapid and her abdominal wall developed a competent scar. At age 39 she had a right oophorectomy for ovarian cyst performed through a midline incision. The wound healed satisfactorily but the scar became thin and within a short time she developed a large ventral hernia. She bore the inconvenience of this hernia for five years and in the interval became markedly obese.

At age 44 she decided to have the hernia repaired and was operated upon at the Cook County Hospital. The immediate results were gratifying but within a year a midline low hernia started. As this enlarged the patient learned how to reduce it by posture and external pressure and sought help only when alarming symptoms appeared.

The patient was operated under local anesthesia. After incision of the skin and subcutaneous fat from the umbilicus to the pubic symphysis, a thin-walled hernial sac was en-

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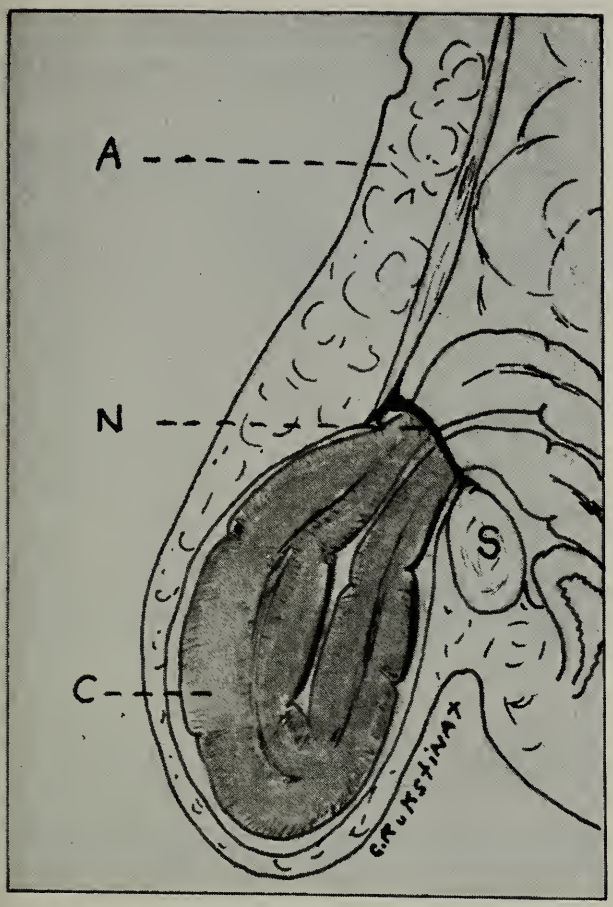


Figure 1. Illustrating at A, the abdominal wall; at N, the neck of the hernial sac; at S, the symphysis pubis and at C, the incarcerated sigmoid part of the colon within the hernial sac.

countered in front of the symphysis pubis. (See Figure 1.) The sac contained thirty cubic centimeters of clear yellow liquid and eight inches of incarcerated sigmoid colon which had herniated through an opening between the transversalis fascia and symphysis pubis. The abdomen was entered through the upper half of the incision and a tight constricting band was found at the neck of the hernial pouch. This band had indented the bowel it encircled and was quickly cut. The bowel, purple and distended, returned to its normal color when the ring was severed. The bowel was then returned to the abdomen and the hernial sac removed. The wall was closed in layers to obliterate the space left after the hernia was reduced and a Penrose drain was inserted.

DISCUSSION

The diagnosis of hernia with a strangulated content was not difficult to make in this instance. The location of the hernia was unusual and its content was exceptional in the experience of the surgeon (F. J. S.). There is room for conjecture as to whether the sigmoid colon had entered the hernia space on the numerous occasions on which the patient had reduced the hernia herself. In reducible hernias small intestine and omentum are usually found. Large bowel is most frequently found in irreducible hernia.

The site of the hernia ring was most unusually low and close to a region of secure fascial attachment. The pendulous and protruding parts of the abdominal wall were apparently the greatest factor in enlarging the hernia, once it had formed. It is also conceivable that the previous operation for ventral hernia was meticulously performed by overlapping the fascial flaps in the upper part of the rupture where tissue was abundant and pliable. The dense fascial close to the symphysis would be less pliant and could not be similarly repaired. This type of repair could even be the basis of the hernia here encountered. The lower edge of the imbricated part of the fascia would form a firm scar. The portion near the symphysis would not share in the new vascularity of this repair and would heal more slowly and imperfectly. The constantly increasing weight of the patient furnished additional intra-abdominal pressure to press against the weak area of the lower abdominal wall and thus the hernia resulted.

Watson[1] describes the etiologic factors pictured above. He indicates that incisional hernia occurs in 2 to 5 per cent of all clean abdominal operations and in 15 to 30 per cent of infected and drainage cases. Benjamin[2] in 1941, found 21.6 per cent of hernias following operations for appendicitis, and 11.2 per cent after operations on the gallbladder. Especially notable is his observation that there was a 36 per cent recurrence rate in operations for incisional hernia.

The last problem has been dealt with in a most elaborate fashion by Wangensteen.[3,4] He has used the iliotibial tract of fascial lata pedicled on the tensor fasciae femoris muscle as a graft to repair large and recurrent ventral hernias. Another method has been devised by Mahorner[5] in which the tissues are first overlapped longitudinally by interrupted silk sutures. Then fascia strips are placed transversely in the wound and sutured to the anterior rectus fascia near the linea semilunaris. These strips relieve tension on the wound.

SUMMARY

A case of strangulation of the sigmoid part of the colon in a ventral hernia is presented. The etiology and treatment of incisional hernia is reviewed in the aspects pertinent to the problem here encountered.

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NEW IDEAS ON THE SPLEEN

Recently Johansen has shown that the spleen, instead of secreting a hormone which inhibits the bone marrow, "sequestres" a substance which normally promotes the function of the bone marrow. In patients with hypersplenism the circulating serum contains a decreased amount of this factor, which soon returns to normal quantities after splenectomy. The spleen of these patients contains an excessive amount of this factor, because when pressed juice of the spleen was used as a nutrient medium in bone marrow cultures there was a 15 per cent increase in the activity of the marrow when compared to normal marrow cultures with serum used as a nutrient medium. "Since it has not been possible to demonstrate the presence of any substance inhibiting maturation, in my opinion this shows that the splenogenic inhibition of the bone marrow in certain clinical pictures is wholly or in part due to a pathologically increased resorption in the spleen of one or more substances which are normally present in the blood and which promote maturation in the bone marrow." *Bernard E. Nunez, M.D. Unusual Diseases Of The Spleen. Med. Ann. District of Columbia, Oct. 1952.*

COUNCIL MEETING MINUTES

MINUTES OF OCTOBER MEETING OF THE COUNCIL

Meeting called to order by the chairman, F. Lee Stone, with following present: Sweeney, Lewis, Muller, Kirby, Camp, Lundholm, O'Neill, Stone, Oldfield, Vaughn, Hesseltine, Blair, Reisch, Newcomb, Goodyear, English, Montgomery, Fullerton, Hellmuth, Limarzi, Hoeltgen, Hedge, Wolff, H. K. Scatliff, I. H. Neece, J. O. Firth, Tom Kirkwood, White, Hopkins, Coleman, Cross, F. E. Bollaert, Leary, Neal and Frances Zimmer. Minutes of last meeting were approved, as sent to members. Secretary had mailed his regular report to members, and gave a supplementary report. He stated that 12 years ago on this date, Roland Cross became Director of the State Department of Public Health, filled the office longer than any other Director. Referred to unusual type of cooperation between this State Department and the Medical Profession of Illinois, as well as this Council. Unfortunately this type of cooperation does not exist in all states. Secretary also told of Dr. Stone's appearance in Detroit as a witness at the hearing of the Committee on the Health Needs of the Nation, this held on September 23. Usual Financial Report was likewise presented to the Council. Secretary directed to send appropriate letter of congratulations and best wishes to Cross, and to tell him of the gratitude of this Society for the fine work he has done in the State Health Department.

Sweeney, reporting as President, told of the many meetings he had attended, and of other invitations he could not accept on account of other commitments. Recommended that the Council designate one member to attend the regular meetings of the Illinois Chamber of Commerce, the Society being a participating organization. Believed we should become more familiar with the activities of this state wide organization.

Lewis reported as President-Elect, giving a statement on his own activities, meetings attended, and future invitations. Stone reported as Chairman of the Council, telling of the interesting meeting at Mt. Carroll, when the entire community paid tribute to three elderly physicians who had jointly given 167 years of service to this small city and surrounding area. Told of his appearance before the Committee on the Health Needs of the Nation, at which he read a 10 minute outline of activities in Illinois. Speakers from individual states only allowed that amount of time, which was completely inadequate to give any expression of health conditions or possible needs for an entire state.

Blair was asked by the Executive Committee at a meeting the previous evening, to outline the aims and objectives of the movement spearheaded by F. E. Bollaert of Moline, which had been widely publicized, and rather generally misquoted. Bollaert is anxious to have a definition of "fee splitting" given by the A.M.A. Judicial Council, which to date had not been given. The Principles of Medical Ethics fails to tell exactly what constitutes fee splitting, and this is what Bollaert and his friends want, a concise clarification of the subject. Bollaert had the support of the Rock Island County Society in the movement, following the reporting of the principles recently adopted by the Iowa State Medical Society.

Bollaert was given the floor and elaborated on the remarks of Blair, and he hoped the Council and State Medical Society would endeavor to get an official clarification on fee splitting from the Judicial Council. His questions: "what is fee splitting?—what is ethical and what is not ethical? When the patient knows two or more physicians participated in the care and each is entitled to remuneration, what difference is there between three fees paid in one check, and payment of

three seperate bills, individually?" No action was taken at this time.

Resolution submitted by Hopkins, as Chairman of Committee on Medical Service and Public Relations in which physicians throughout Illinois were requested to close their offices on election day and assist in getting people to the polls. Voters regardless of party affiliations should exercise their constitutional right to vote, and this year an all out effort to get out a large vote should be instituted. By proper action, the resolution was sent to all county societies for their own action, as desired.

Hopkins referred to the work of the Illinois Interprofessional Council of which Wayne Slaughter is chairman. They are having regular meetings, and it seems quite probable that a closer relationship will be developed among the several participating organizations. Leary and Neal also discussed some of the problems in their divisions of the Committee functions. Blair reporting as chairman of the Educational Committee reported that the TV health broadcasts would be back on the air the latter part of November. The kinoscope authorized by the Council is now available, and will be shown to the Council at the next meeting if desired, and time is available for its showing. Routine matters of the committee were presented in the report. Limarzi is still investigating the possible plans to teach technicians prothrombin consumption time laboratory technique. The Illinois Society of Pathologists has a committee on laboratory standards under the jurisdiction of Dr. Opal Hepler, of Northwestern University Medical School, Chicago 11, and any hospital can write to her for information relative to their classes or their services.

The Scientific Service Committee recently held a meeting and discussed its work for the next year. Invited speakers are restricted to members of this Society, Doctors of Philosophy and other scientists. Permission has been given however, for downstate societies to use speakers from St. Louis and Iowa City, if more conveniently located. A re-survey of county societies is under way and they hope to have an interesting report for publication in the near future. The revised list of speakers will be developed soon, and ready for publication. A report will be forthcoming at the next Council meeting on this subject. A physician recently wrote to many county societies offering his services, being willing to appear on programs at almost any time they desire it. They are urged to clear through the committee before an appearance before societies.

Coleman told of the meeting the previous evening, of the Medical Advisory Committee to the I.P.A.C. and many of the things which were discussed. Some of these were definitely controversial and a further and perhaps more complete report will soon be available. The committee although realizing they are dealing with people in extremely low income groups, are desirous of seeing they receive decent care, even though the rate must remain less than that received in private practice. The Advisory Committee to the United Mine Workers met recently in Springfield to consider plans for the continuance of their functions. Physicians are urged to restrict their charges within the adopted fee schedules, and the committee hopes to continue in its advisory functions for the mutual interests of the patients of the U.M.W.A. and the participating physicians.

Hellmuth told of the post graduate work under way, and proposed, the plans have been slowed down and are starting later this year. Efforts will be made to avoid conflicting dates of other societies and their meetings. Told of the plan to get public ambulance service in the Chicago Metropolitan area sponsored by the Institute of Medicine. This organization would like to have the expression of the Illinois State Medical Society and the Chicago Medical Society. By proper action, the Council indicated its interest in the proposal, which information would go to the Institute of Medicine.

Wolff reported as chairman of the Committee on Medical Economics, telling of the efforts to get regular articles in the Illinois Medical Journal. They now have a small backlog of articles which will be published monthly. The committee is anxious to have expressions from the Council and membership as a whole, on what type of articles they would prefer to have presented. Muller told of plans of the local groups for selecting all necessary committees to constitute the Committee on Arrangements for the 1953 annual meeting. The Auxiliary would like to have a fitting celebration of their 25th anniversary in 1953, and presently plan to have a big party on Tuesday evening, if that time will be made available for same.

Scatliff continued the report from the Auxiliary, he being chairman of the Liaison Committee from the State Medical Society. They are elated over the arrangement to have their session in the same hotel next year. Hesseltine told of the 25th anniversary celebration of the University of Chicago Clinics, he being the official representative from this Society. They had an excellent program which was well received. Cross gave his regular, highly interesting report of health conditions throughout Illinois. The tuberculosis program is going along fine; the 100 bed tuberculosis hospital in Mt. Vernon is now operating with a patient load of 96, only four below the maximum capacity. The Chicago hospital to be opened in the near future. Death rates from tuberculosis are steadily decreasing throughout the state.

Hoeltgen gave an interim progress report as chairman of the Committee on Nursing. The long report was attached to the minutes of the meeting, sent out from the Monmouth office to all members. He told of the survey under way on the nursing situation, and nursing needs over the state and nation in general. O'Neill, Montgomery and others discussed the increase in annual dues for 1953, the $20.00 increase to go into the Medical Educational Fund, to aid medical schools over the country, which can no longer operate from student income alone.

Although the By-laws of the Society make citizenship essential for membership in the Society, several societies in Illinois have overlooked this fact, and have taken in, illegally some who have not acquired citizenship. By proper action, the secretary was instructed to notify all

(*Continued on page* 64)

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Mediastinal Carcinoma

J. C. Sherrick, M.D.
Wesley Memorial Hospital

CLINICAL HISTORY

This 56 year old white male was admitted to the hospital because of chest pain of one year's duration.

PRESENT ILLNESS: The patient was well until one year before admission when he noted a dull constant ache in the back that radiated to the front of the left side of his chest. Occasionally the pain radiated down the back and to the left arm, was persistent and gradually became more severe. There was no hoarseness, cough or dyspnea. About one month before admission x-ray of the chest revealed increased prominence of the arch of the aorta with moderate displacement of the trachea to the right. On oblique and lateral projections, there was a large retrotracheal homogeneous shadow with fairly sharply demarcated borders that displaced the trachea anteriorly and reduced its lumen to about half of normal. This mass exhibited slight pulsation. After the intravenous injection of 70% diodrast there was no unmistakable filling of the mass but a general increase in density of the retrotracheal mass was noted. There were also numerous small parenchymal calcifications above the third chondro-sternal junction in the right lung. No erosion of the ribs was seen.

PAST HISTORY: He had had frequent colds and pneumonia. A few small areas of increased density were noted in the upper lobe of the right lung 7 years ago. Serial x-rays showed no change in this infiltration. The family history was non-contributory.

PHYSICAL EXAMINATION: The temperature was 97 degrees F., pulse 100, respirations 20, and blood pressure 154/86 mm. Hg. The patient was a well developed and well nourished white male, not acutely ill. The neck was supple. There was no tracheal tug or distention of neck veins. The chest was clear. The superior mediastinal dullness was not widened. The heart was enlarged 1 cm. beyond the midaxillary line in the fifth interspace and 1.5 cm. to the right of the sternum. No thrills or murmurs were heard. The blood pressure levels were about the same in both arms, but the right peripheral pulse was slightly stronger. The abdomen was soft and no organs were palpated. Neurologic examination was normal.

LABORATORY EXAMINATION: The

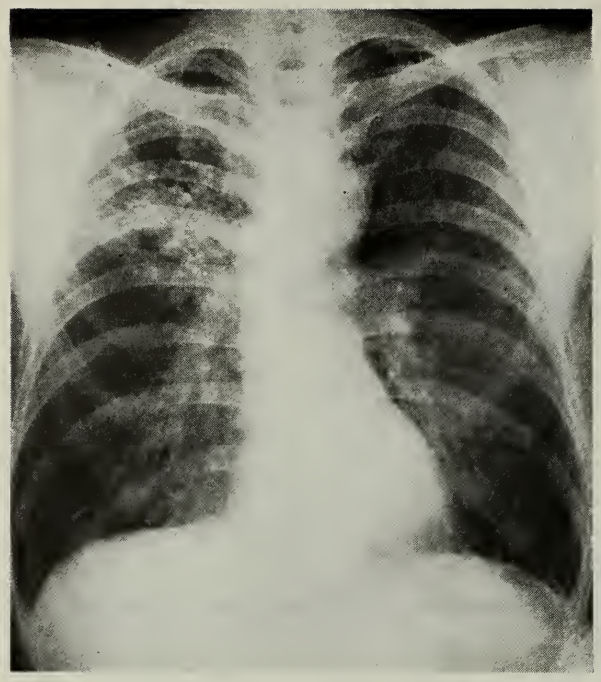


Figure 1. Chest x-ray 3 years before admission.

urinalysis was normal. The blood had 10 gm. of hemoglobin per 100 c.c. and 4,730,000 erythrocytes per Cu. mm. The white cell count was 9,600 with a normal differential. The blood Kahn was negative. A chest x-ray on admission revealed no change in the superior mediastinal mass. Bronchoscopy and sputum examination were not done.

On the second hospital day an operation was performed.

CLINICAL DISCUSSION

DR. FREDERICK W. MUNSON* — This 56 year old patient was admitted because of chest pain, sometimes in the back and sometimes down the left arm. The physical examination was essentially normal except for slight cardiac enlargement which was not confirmed by chest x-rays. The neurological examination was normal. Because of parenchymal infiltration in the upper lobe of the right lung, thought to be tuberculosis, the patient had been followed with chest x-rays which showed increasing mediastinal enlargement. This enlargement was localized to the upper mediastinum by the marked displacement of the trachea. The differential diagnosis of superior mediastinal masses essentially falls into two groups — tumor and aneurysm. The patient's Kahn was negative. I will ask Dr. Cannon to review the x-rays.

*Attending physician, Wesley Memorial Hospital.

DR. ABRAHAM H. CANNON: We have films going back 7 years, at which time there was infiltration in the right upper lung field. Over the years this lesion showed slight changes, but finally was stabilized three years ago. (Figure 1) However, we continued to take x-rays every 6 months and 18 months ago we began to notice a change in the region of the aortic arch. Three months later this had become larger and since then has remained approximately the same size. Six months ago we studied the mass a little more thoroughly (Figure 2 & 3). Lateral and oblique films show that this is a superior mediastinal mass which markedly displaces the trachea anteriorly and to the right. Diodrast was then injected and an angiogram was done. There was much debate in the department about the exact interpretation of the films, as you can see from the rather cautious interpretation given in the clinical history. The mass gives the impression of increasing in density after the intravenous administration of diodrast. Perhaps it increased somewhat less in density than an aneurysm usually does. Fluoroscopy does not give much help. Although the mass did show some pulsation we were not able to say whether it was an expansile or a transmitted pulsation. We also took a film of the abdomen. This gives us a fairly good view of the urinary tract. The right kidney is larger than normal and is

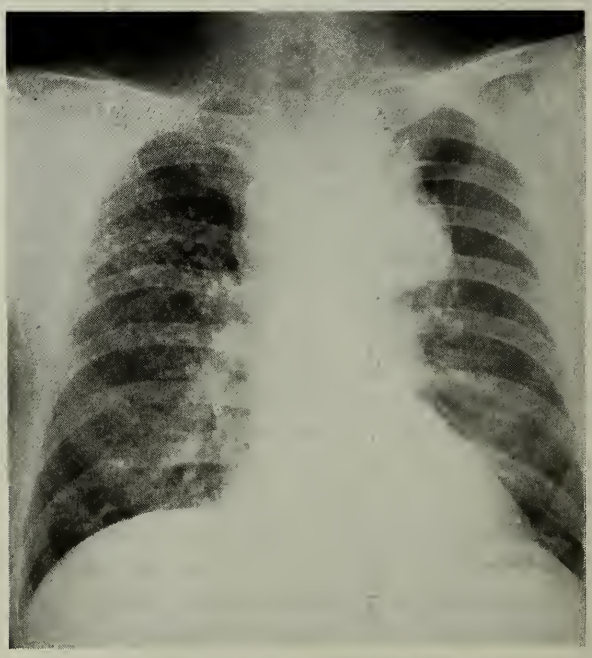


Figure 2. Chest x-ray 6 months before admission.

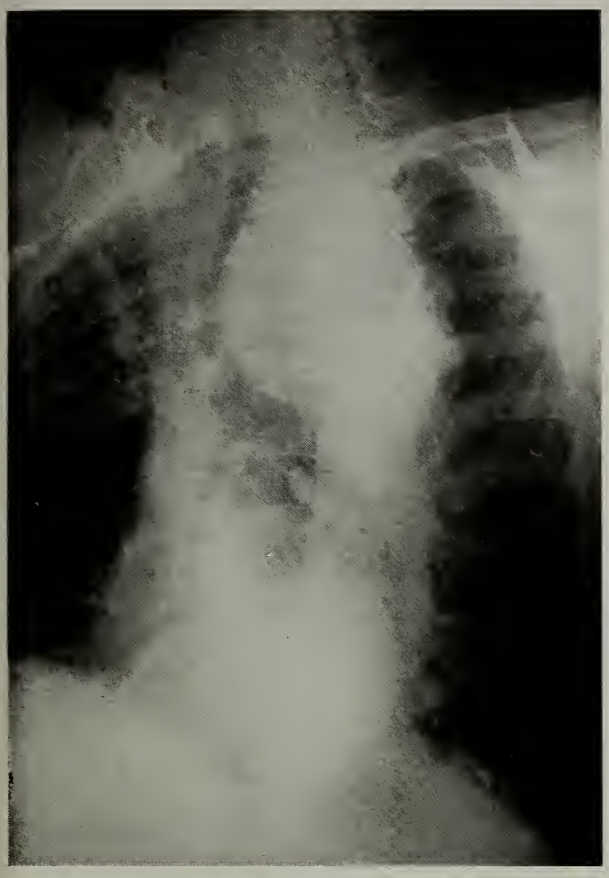


Figure 3. Oblique chest x-ray 6 months before admission.

elongated. The inferior calyx is distorted, although there is no definite erosion of the calyces. The impression is that of a spherical mass at the lower pole of the left kidney. The bladder has a peculiar shape, probably because of hypertrophy of the prostate.

DR. MUNSON: Since an aneurysm was not fully demonstrated, I will ignore it in my differential diagnosis, perhaps wrongly. The tumors to consider in this region include neurofibroma or neuroganglionoma, which are often found in the posterior mediastinum. The pain down the left arm would be consistent with such a tumor. Pericardial cysts are sometimes found in the mediastinum. Substernal thyroid may also be found in this location, but because of absence of anything above the mediastinum, we can eliminate that. Other tumors, such as lymphoma, are more apt to be associated with enlargement of the hilus of the lung. Thymoma must be considered. Because of the abdominal film one must consider the rather unusual possibility of secondary carcinoma from a kidney tumor. My first diagnosis is carcinoma of the lung with unusual extension to the mediastinum and my second diagnosis would be carcinoma of the kidney with metastases.

DR. JEROME R. HEAD: We first saw this patient 8 years ago and believed that he had pulmonary tuberculosis, although his sputum and gastric washings were negative for acid fast bacilli by guinea pig inocculation. The lesion contracted and healed after 6 months in the sanitorium, and on routine check-ups we noted this enlargement of the mediastinum. Our differential diagnosis was much the same as Dr. Munson's. However, we thought well enough of the possibility of aneurysm to operate on the patient and were prepared to introduce wire if necessary. In general, in these cases, we depend on the Kahn test: if it is positive we make the diagnosis of aneurysm and if negative we believe that tumor is the best possibility.

DR. ARTHUR E. MAHLE: This sounds more to me like carcinoma of the kidney with metastases to the mediastinum. Was the blood pressure the same in both arms?

DR. THOMAS C. LAIPPLY: The blood

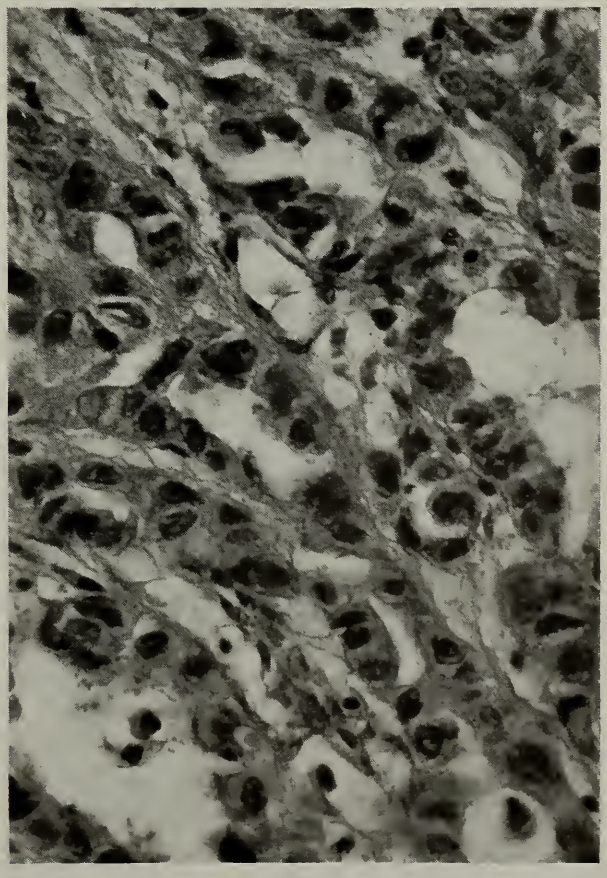


Figure 4. Photomicrograph of tumor.

pressure was the same in both arms.

DR. EDWARD AVERY: A single metastasis to the mediastinum would be extremely rare. There should be more paraaortic lymph node involvement.

DR. PATRICK RILEY: Is not the retrotracheal position of the mass unusual for aneurysm of the aorta?

DR. HEAD: According to Osler an aneurysm can do anything. This aneurysm was on the left side and in this case a saccular aneurysm might go behind the trachea.

CLINICAL DIAGNOSIS

Aortic aneurysm.

DR. MUNSON'S DIAGNOSIS

Carcinoma of lung with extension to the mediastinum.

ANATOMICAL DIAGNOSIS

Poorly differentiated adenocarcinoma.

PATHOLOGICAL DISCUSSION

DR. THOMAS C. LAIPPLY: The tissue received was from the mediastinal mass. Microscopic examination (Figure 4) showed fibrous connective tissue containing many tumor glands, which varied in size and shape, and were lined by pleomorphic epithelial cells. There was marked nuclear pleomorphism with many bizarre nuclear forms and atypical mitoses. Microscopically this is not the typical picture of clear cell carcinoma of the kidney. Special stains failed to show mucin or cilia in the tumor. The patient is still alive and the primary site of the tumor has not been established. This tumor may be secondary to a primary carcinoma of the kidney. Nevertheless, primary adenocarcinoma of the lung with invasion of the mediastinum seems more likely.

THE OTHER GUY

"An American soldier, wounded on the battlefield in the far East, owes his life to the Japanese scientist Kitasato, who isolated the bacillus of tetanus. A Russian soldier saved by a blood transfusion is indebted to Landsteiner, an Austrian. A German is shielded from typhoid fever with the help of a Russian, Mechnikoff. A Dutch marine in the East Indies is protected from malaria because of the experiments of an Italian, Grassi; while a British aviator in North Africa escapes death from a surgical infection because, through the discoveries of a Frenchman, Pasteur, and a German, Koch, a new technique was elaborated. In peace as in war we are beneficiaries of knowledge contributed by men of every nationality. Our children are protected from diphtheria by what a Japanese and a German did; they are protected from smallpox by the work of an Englishman; they are saved from rabies because of a Frenchman; they are cured of pellagra through the researches of an Austrian. From birth to death they are surrounded by an invisible host, the spirits of men who never thought in terms of flags and boundary lines, and who never served a lesser loyalty than the welfare of mankind." *W. R. Wallace, What Makes The Profession Of Medicine Great. (Quoted from the Rockefeller Foundation Report for 1942.). South. Med. & Surg. Mar., 1952.*

NEWS OF THE STATE



CHAMPAIGN

Social Affair.—The Champaign County Medical Society and its Woman's Auxiliary held separate business meetings at the Hotel Tilden Hall, Champaign, December 11, but met together later for dinner and a social evening. Entertainment included an exchange of gifts and bingo.

COOK

Warren Cole Opens Student Lecture Series.—Warren Cole, M. D., professor of surgery, University of Illinois College of Medicine, gave the first lecture January 6, in the series sponsored by the Student American Medical Association at the Chicago Medical School. Dr. Cole's subject was "Diseases of the Gallbladder."

Appointments at Illinois.—Appointment of Drs. Lewis C. Hitchner, Grant C. Johnson, Walter S. Moos, and Max E. Rafelson, to the faculty of the University of Illinois College of Medicine with the rank of assistant professor has been approved by the Board of Trustees.

Dr. Hitchner will serve as clinical assistant professor of anesthesiology. He presently is associated with the Evangelical Hospital of Chicago, and is president of the Illinois Society of Anesthesiologists.

Dr. Johnson will have the rank of assistant professor of pathology in the College of Medicine, and assistant pathologist in the Research and Educational Hospitals, beginning Feb. 1, 1953. He presently serves as a captain in the U. S. Army Medical Corps, and is assigned to the 3rd Army Medical Laboratory at Fort McPherson, Ga.

Dr. Moos will serve with the rank of assistant professor of radiology and radiation physicist in the College of Medicine. Prior to joining the University of Illinois faculty in November, he held an United States Public Health Service fellowship at the National Cancer Institute, Bethesda, Md.

Dr. Rafelson has been appointed with the rank of assistant professor of biological chemistry, beginning Feb. 1, 1953, when he returns from Sweden. He presently is a post-doctoral research fellow of the U. S. Public Health Service.

Dr. Bucy Given New Honor.—Paul C. Bucy, M.D., professor of neurology and neurological surgery at the University of Illinois, will be the first in a series of distinguished surgeons who will occupy the newly established George A. Ball visiting professorship in surgery at the Indiana University School of Medicine.

Dean John D. VanNuys of Indiana has announced that Dr. Bucy will spend each Friday during the present academic year on the Indianapolis campus. Dr. Bucy will take an active part in the surgery teaching program for students as well as post-graduate sessions for surgeons in the state.

Three of Indiana's medical faculty are former students of Dr. Bucy, having served as residents at Chicago Memorial Hospital. They are Robert F. Heimburger, M.D., who is in charge of neurological surgery; John F. Russell, M.D., a member of the Department of Neurological Surgery; and L. W. Freeman, M.D., who is in charge of surgical research.

The new chair in surgery was established by the Riley Memorial Association in honor of the Muncie, Ind., philanthropist for whom it is named.

Grants for Research.—The Chicago Medical

School has recently received two new research grants totalling $10,508. From the National Heart Institute $5,508 goes to Dr. Peter Gaberman, principal investigator, and personnel consisting of Drs. Donald H. Atlas and Harry F. Weisberg, for studies of "The Mechanism of Congestive Failure." Dr. Philippe Shubik, with Dr. A. Robert Goldfarb as collaborator, has been awarded $5,000, which is a renewal and increase over last year, from the Atomic Energy Commission for "Study of the Carcinogenic Effect of Beta Radiations."

Personal.—Mark T. Goldstine celebrated his fiftieth anniversary as a member of the medical staff at Memorial Hospital. —Dr. Michael H. Ebert, Chicago, was elected president of the American Academy of Dermatology and Syphilology recently.

Special Society Election.—Recently elected officers of the Chicago Society of Allergy are Milton M. Nosko, Chicago, president; Abe L. Aaronson, M.D., Chicago, president-elect, and Simon S. Rubin, Gary, Ind., secretary-treasurer.

GREENE

Symposium on Neurological Examination.—The Greene County Medical Society devoted its meeting, December 10, at Roodhouse to a symposium on the importance of the neurological examination. With F. Garm Norbury, M.D., Medical Director of the Norbury Sanatorium, Jacksonville, presiding as moderator, the following spoke: A. M. Paisley, M.D., A. G. Schultz, M.D., and Walter L. Frank, Jr., M.D., all of Jacksonville.

KNOX

One Hundred Years of Medicine.—One hundred years of medicine in Knox County was observed Wednesday November 19, 1952. A special scientific program was presented by the Knox County Medical Society in the Ballroom of the Custer Hotel, Galesburg, Illinois.

The first Knox County Medical Society was established in 1852 with a few members. Present membership of the society is forty-eight. One charter member of the present society, who is also a fifty year club member attended, Ben D. Baird, M. D. of Galesburg, Illinois. Another fifty year club member was present, E. N. Nash, M.D. of Galesburg, Illinois. The Illinois State Medical Society was represented by the Secretary-Treasurer, Harold M. Camp, M.D. of Monmouth, Illinois.

The first speaker at the anniversary event was Gilbert H. Marquardt, M.D., assistant professor of medicine, Northwestern University Medical School, noted for his work in conditions that affect the aged. He discussed "Problems in Geriatric Medicine". Discussion for this presentation was opened by James W. Marshall, M.D., Monmouth, Illinois.

The second speaker was Edwin N. Irons, M.D., clinical assistant professor of medicine (Rush), University of Illinois College of Medicine, who is an authority on the newer drugs, known as antibiotics, such as terramycin, aureomycin and streptomycin. Dr. Irons' subject was "Present Concept of Antibiotics Therapy". Discussion was opened by James C. Redington, M.D., Galesburg, Illinois. A social hour concluded the afternoon session.

The principal speaker at the dinner meeting was Warren H. Cole, M.D., professor and head of the department of surgery at the University of Illinois College of Medicine, Chicago, Illinois, since 1936, who has held various offices in the numerous societies concerned with his specialty, including the presidency of many. Dr. Cole talked on "Intestinal Obstruction". Dr. Cole's presentation was discussed by William Standard, M.D., of Macomb, Illinois.

The program was arranged by the Scientific Service Committee of the Illinois State Medical Society of which Louis R. Limarzi, M.D., associate professor of medicine at the University of Illinois College of Medicine, is Chairman, and Harold M. Camp, M.D., Monmouth, Illinois, Secretary-Treasurer of the Illinois State Medical Society.

Presiding officers at the one hundredth anniversary celebration were Frank M. Huff, M.D., President of the Knox County Medical Society, and Alexander M. Duff, Jr., M.D., Secretary-Treasurer, of Galesburg, Illinois.

Lowell C. Neveln, M.D., Secretary,
Public Relations Committee,
Knox County Medical Society

LA SALLE

Medico-Legal Meeting.—Louis W. Shabat, M.D., Chicago, addressed a joint meeting of the La Salle County Medical and Bar Associations, December 11, at a dinner session in the Ottawa Boat Club. His subject was "Medical Preparation in Personal Injury Law Suits."

MADISON

Society News.—J. H. Ogura, M.D., St. Louis, assistant professor of otolaryngology at Washington University School of Medicine, addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, December 4. His subject was "The Nose."

MORGAN

Sanatorium Entertains County Society.—The Morgan County Medical Society was the guest, November 13, of the Norbury Sanatorium in Jacksonville. Dr. Ernest Parsons, assistant professor of clinical psychiatry, Washington University School of Medicine, St. Louis, gave the principal address on "Patients are People."

SANGAMON

Society News.—Charles Newberger, M.D., discussed "Maternal Mortality" before the Sangamon County Medical Society at its dinner meeting in the Elks Club, Springfield, December 4.

WINNEBAGO

Decision on Treatment Center Theme of Meeting.—A special meeting was called by the Winnebago County Medical Society at the Lafayette Hotel, December 12, to consider whether or not the Rockford Chapter of the Illinois Association for Crippled should establish a treatment center in Rockford.

GENERAL

Roy Gibbons and Herold Hunt Honored.—Roy Gibbons, science editor of the Chicago Tribune, and Dr. Herold Hunt, superintendent of Chicago schools, were made honorary fellows of the Institute of Medicine of Chicago, December 2.

Gibbons' certificate, conferred by Walter H. Theobald, M.D., states that he is honored for "rendering conspicuous service by up to the minute press coverage in the field of medicine, allied services, and public health," and adds that "He is the first man in scientific journalism to receive this distinction from the institute."

Dr. Hunt's certificate, conferred by John L. Reichert, M.D., recognizes his "outstanding contributions to the welfare of Chicago."

New Officers of Illinois Chapter A. C. of S.—Robert J. Patton, Springfield, was chosen president of the Illinois State Chapter of the American College of Surgeons at its annual meeting in Peoria, November 1. Other officers are Charles D. Branch, Peoria, vice president; Kent W. Barber, M.D., Quincy, secretary treasurer, and Charles E. Baldree Jr., M.D., Belleville, councilor. Principal speaker at the meeting was Kenneth Schnepp, M.D., on "Electrolyte Balance."

Menus for Sodium Restricted Diet.—"Preparing Meals for the Sodium Restricted Diet" is the title of a 12 page piece of mimeographed material recently made available to physicians by the Diet Therapy Committee of the Illinois Dietetic Association. The collection is not in the main a recipe or another cook book, but, while it does give some recipes, its greatest use will be found in showing persons how to adjust their favorite recipes to the low sodium regimen. It should be used as a supplement to the dietary instructions given by the physician.

Pages are included on such subjects as—general suggestions, menus, foods usually permitted on a low sodium diet; ideas for food selection when meals are "eaten out"; in addition there are suggestions for flavoring various types of dishes when sodium is to be omitted.

The material is intended for use by physicians and dietitians in Illinois to give to the patient, and not to be secured directly by the patient. The price is ten cents a copy (stamps will not be accepted) and may be secured singly or in quantities at that price. Temporarily the mimeographed outline can be secured from the Diet Therapy Committee of the Illinois Dietetic Association by address Miss Mame Dentler, 303 East Chicago Avenue, Chicago 11.

HEALTH DEPARTMENT ACTIVITIES

New Sewerage System for Rockton.—The Illinois State Sanitary Water Board has granted the Village of Rockton, Winnebago county, a permit to construct and maintain a municipal sanitary sewerage system and treatment works, it was announced recently by Clarence W. Klassen, technical secretary of the board.

The system will discharge into the Rock River.

The planned sewerage system will, Klassen stated, "facilitate more practical utilization of the existing public water supply system of the town, will provide for better sanitation and promote the general welfare of the community."

Pneumonia Leading Mortality Cause in Communicable Diseases.—Nine major communicable diseases caused the deaths of 2,710 Illinois residents during the first six months of 1952, according to a report issued by the state department of public health. The same nine diseases were responsible for 2,724 deaths during the first half of 1951.

The leading cause of death among the communicable diseases was pneumonia which brought on 1,377 fatalities in the six-month period. Tuberculosis in all forms was responsible for 909 deaths and pulmonary T.B. was the cause of 823.

Syphilis killed 261 persons; influenza, 80; meningitis, 50; measles, 20; poliomyelitis, 7; whooping cough, 5, and diphtheria, 1.

Pneumonia deaths increased by 17 in the comparative periods. Syphilis caused seven more fatalities. Meningitis deaths rose 25, polio, one; and the single diphtheria death compared to a complete absence of mortality from this illness during the first half of last year.

Deaths from tuberculosis in all forms dropped by 54 and pulmonary T.B. deaths were 72 fewer. Influenza deaths fell three; measles, six, and whooping cough, two.

Third Narcotic Clinic.—Chicago's third State-supported narcotics clinic, located at the Northwestern University Medical Center, has been opened, it was announced by Dr. Roland R. Cross, director of the Illinois Department of Public Health.

This clinic which will provide medical counseling for narcotic addicts and youth in the pre-addiction stage is headed by Dr. Benjamin Boshes.

Other clinics operating in cooperation with the state health department are located at Provident hospital and the University of Illinois medical center.

Reporting on the work of the clinics since the first (Provident) opened last December 1, Dr. G. Howard Gowen, deputy director in charge of the department's narcotic program said that there have been 170 referrals.

Eighty per cent of the persons referred to the clinics have been in the 17 to 28 age bracket and 30 per cent of the total ranged from 17 to 20 years of age.

Male referrals outnumbered females five to one in the first 11 months. Most of these persons were

single or separated from their families.

Other information given by the narcotics patients showed that most of them were in the low or middle-low income group and two-thirds were unskilled laborers. Only 25 per cent had graduated from high school. About 10 per cent had attended college for some time.

Dr. Gowen listed three classes of individuals who had been referred to Provident and the University of Illinois clinics. They are 1. Chronic addicts; 2. Persons who had undergone treatment, and 3. Pre-addicts, such as users of marijuana.

In the case of the chronic addicts, the main task has been persuading them to undergo withdrawal treatment. If this is accomplished the next job is to get the treated persons back to the clinic for counseling and guidance. The main objective of the post-treatment counseling is to help persons accept responsibility and to repress further desire for drugs.

Work with the early addicts consists of study of the person, his family and environment to determine conflicts which have led to use of dope. When the cause or causes are discovered the clinic psychiatrists and social workers try to remove the person from the unhealthy situation or to correct the situation.

Although it is too early to say definitely that the State's program is meeting a high degree of success, Dr. Gowen said, limited experience to date has shown that 82 per cent of the persons treated in the clinics have not returned to use of narcotics.

"How's Your Health" over WGN-TV.—On November 26, the Educational Committee of the Illinois State Medical Society returned to the air over *WGN-TV, Channel 9,* with a repeat telecast with *Richard J. Bennett,* surgeon, Chicago District, U. S. Steel Company, and *Theodore R. Van Dellen,* Medical Editor of the Chicago Tribune. Title of the telecast was "What Is a Rupture?"

After programming for three and one half years with the title "Health Talk," the Educational Committee voted to change the name of the telecast to *"How's Your Health."*

Subsequent programs were:

Robert T. McElvenny, assistant professor of bone and joint surgery, Northwestern University Medical School, December 3, Watch Your Child's Back.

Lawrence Peterson, attending surgeon; *Allen Hrejsa,* assistant attending surgeon, *Irwin Dritz,* anesthetist, *Sanford Franzblau,* internist, *Robert McNerland,* patient, and Registered Nurses *Joan Dean, Fern Yates, Joanne Chambers* and *Ann Marie Janzer,* all of the staff of Illinois Masonic Hospital, in Emergency. Elaborate equipment to simulate a real operating room was provided by *V. Mueller and Company, Ohio Chemical Company, Abbott Laboratories* and *Illinois Masonic Hospital.* So realistic was the effect of this program that even professional persons believed the program to be coming from a hospital.

Edward K. Isaacson, director, outpatient pediatric clinic, Northwestern University Medical School, and Theodore R. Van Dellen, December 17, in "Why Immunize."

Telecasts were not scheduled for Christmas Eve and New Year's Eve.

"Your Doctor Speaks" over FM Station WFJL.—In the radio series "Your Doctor Speaks" over FM *Station WFJL,* the following physicians presented transcribed broadcasts under the auspices of the Educational Committee of Illinois State Medical Society:

Frank M. Quinn, member of the Illinois Academy of General Practice, October 9, on What Preventive Medicine Holds for You.

Warren W. Young, member of the staff, Roseland Community Hospital, October 23, on Diabetes.

Stanley W. Olson, dean, University of Illinois College of Medicine, October 30, When Are we Going to Get More Doctors?

Roland R. Cross, Jr., instructor in urology, Northwestern University Medical School, November 6, The Prostate in Man.

Oscar Sugar, assistant professor of neurological surgery, University of Illinois College of Medicine, November 13, on Stroke.

Joseph T. Gault, attending surgeon, Mount Sinai Hospital, November 20, on Tumors of the Female Breast.

Aldo A. Luisada, director, division of cardiology, Chicago Medical School, November 27, on Rheumatic Fever and Rheumatic Heart Disease.

Donald H. Atlas, associate professor of medicine, Chicago Medical School, December 4, The Pitfalls of Self-Medication.

Frank E. Doyle, member of the staff of St. Anne's Hospital, December 11, on Care of the Aged.

Harry F. Weisberg, clinical chemist, Mount Sinai Medical Research Foundation and Hospital, December 18, The Role of Laboratory Tests in Clinical Medicine.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Joseph T. O'Neill, Ottawa, McKinley School PTA in Marseilles, November 4, on Emotional Problems in the Early School Child.

Dietrich Klemptner, Chicago, Women's American ORT, Sheridan Chapter, November 19, in Chicago, on Growing Old Gracefully.

Lawrence Breslow, Chicago, November 19, Austin Jewish Community Center Sisterhood, on Emotional Problems of the Adolescent.

Burtis E. Montgomery, Harrisburg, West Frankfort Woman's Club, December 2, in West Frankfort, Growing Old Gracefully.

F. Garm Norbury, Jacksonville, Illinois Welfare Association (Region 6), in Winchester, December 16, on Patients are People.

Paul K. Anthony, Chicago, January 6, Women's American O.R.T., Jeffery Manor Chapter, January 6, on Problems of Parenthood.

Albertine L. Rea, Chicago, Norwegian Women's Club, January 7, in Chicago, on The Best is Yet to Be.

John F. Carey, Joliet, Steger PTA, January 13, in

Steger, on Health of the School Child.

Felix A. Tornabene, Aurora, Young Mothers' Club, January 14, on Latest Developments in Medical Research.

George L. Perkins, Chicago, Washington School PTA in River Forest, January 20, on Common Emotional Disturbances of 4 to 12 Year Olds.

Charles S. Gilbert, Chicago, Berwyn Woman's Civic Club in Berwyn, January 20, on Safe Reducing.

Burton C. Kilbourne, Chicago, Vanderpoel PTA January 23, on An Eye to the Future—in Healthy Children.

Edward L. Jackson, Oak Park, Gage Park Woman's Club in Chicago, January 27, on Superstitions About Health.

Miss Marion Gridley, Chicago, Northwest Branch Auxiliary to the Chicago Medical Society, January 27, on Indians of the United States.

Margarete M. Kunde, Chicago, Catholic Daughters of America in West Chicago, February 3, on Diet, Reducing and Vitamins.

Eugene J. Ranke, Chicago, Woman's Auxiliary to the Chicago Medical Society, February 10, on Nutrition from Cradle to Grave.

Carlos I. Reed, Ph. D., Chicago, Physicians' Fellowship Club Auxiliary, February 13, on Water, Soil and Human Nutrition.

Eugene L. Slotkowski, Chicago, Schubert School PTA in Chicago, February 17, on Understanding the Adolescent.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Thomas H. Burford, St. Louis, Montgomery and Macoupin County Medical Societies in Litchfield, December 9, on Carcinoma of the Lung.

Myron M. Hipskind, Chicago, Fulton County Medical Society, December 10, in Canton, on Differential Diagnosis of Vertigo (motion picture presentation).

Thomas D. Masters, Springfield, Rock Island Chapter, Illinois Academy of General Practice in Rock Island, December 16, on Medical Management of Thyroid Disturbances.

Harry E. Mock, Jr., Chicago, Lee-Whiteside County Medical Societies in Dixon, December 18, on Prevention and Management of Brain Injuries.

Patrick H. McNulty, Chicago, DeKalb County Medical Society in Sycamore, December 30, on Anuria.

Jerome T. Paul, Chicago, McLean County Medical Society in Bloomington, January 13, on Diagnosis and Treatment of Diabetes Mellitus.

Thomas J. Coogan, Chicago, Lee-Whiteside County Medical Societies at Forest Inn near Sterling, January 15, on Modern Trends in Treatment of Vascular Diseases.

James H. Cross, Chicago, Logan County Medical Society, January 15, in Lincoln, on Lesions of the Esophagus.

Walter J. Reich, Chicago, Stock Yards Branch of the Chicago Medical Society, January 15, on Management of Cervical Erosion.

August F. Daro, Chicago, DeKalb County Medical Society in Sycamore, January 27, on Recent Advances in Obstetrics.

Harvey S. Allen, Chicago, Lee-Whiteside County Medical Societies in Dixon, February 19, on Injuries of the Hand.

Mitchell A. Spellberg, Chicago, Stock Yards Branch to the Chicago Medical Society, February 19, on Diagnosis and Management of Colitis.

Carlo Scuderi, Chicago, DeKalb County Medical Society in DeKalb, February 24, on Treatment of Both Bone Fractures of the Leg.

MARRIAGES

Charles E. Galloway, Evanston, to Dorothy Schmidt, at First Congregational Church in Wilmette, November 29.

DEATHS

Waldo Brown Baird, Mt. Carmel, who graduated at Eclectic Medical College, Cincinnati, in 1910, died October 17, aged 69, of metastatic sarcoma of the cerebrum.

Robert Webster Binney, Granite City, who graduated at Washington University School of Medicine, St. Louis, in 1897, died October 28, aged 79, of cerebral hemorrhage. He was a member of the U. S. Chapter of Surgeons of Geneva, American Association of Industrial Physicians and Surgeons' Club of the Mayo Clinic.

George R. Blackstone, retired, Urbana, who graduated at Northwestern University Medical School in 1900, died recently, aged 77.

John W. Blair, Homewood, formerly of Harvey, who graduated at Dunham Medical College, Chicago, in 1900, died in November, aged 76.

N. Lionel Blitzsten, Chicago, who graduated at Rush Medical College in 1917, died September 27, aged 59, of chronic myocarditis. He was on the faculty of Northwestern University Medical school for many years, where he was an associate in the department of nervous and mental diseases.

Londus B. Brannon, Manhattan, who graduated at Northwestern University Medical School in 1931, died December 1, aged 51.

Stanley L. Brown, Chicago and Hammond, (Indiana), who graduated at Northwestern University in 1909, died December 8, aged 68.

Frank J. Chmelik, Joliet, who graduated at Chicago College of Medicine and Surgery in 1916, died December 8, aged 61. He had been penitentiary physician for 25 years and was also physician for the Joliet police and fire board.

Elias L. Davis, Peoria, who graduated at Barnes Medical College, St. Louis, in 1896, died November 9, aged 84.

Amos DeFeo, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died October 30, aged 62 of coronary occlusion.

Matt Elsen, Winnebago, who graduated at Northwestern University Medical School in 1917, died recently, aged 65, in Rockford Memorial Hospital. He had practiced medicine in Winnebago for the past 28 years.

William E. Guinea, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died November 22, aged 60, in Little Company of Mary Hospital, where he had been a staff member for 15 years.

William N. Hamilton, Odin, who graduated at St. Louis University School of Medicine in 1903, died recently, aged 85.

Mortimore C. Hawk, Blue Island, who graduated at University of Pittsburgh School of Medicine in 1896, died September 1, aged 79, of coronary thrombosis.

Marie Sorna Levinson, retired, Chicago, who graduated at the College of Medicine and Surgery, Chicago, in 1908, died November 28, aged 75.

Anthony E. Malachowski, retired, Bensenville, formerly of Chicago, who graduated at Illinois Medical College in 1904, died December 7, aged 79, in Belmont Hospital.

Victor A. McClanahan, Aledo, who graduated at Keokuk Medical College in 1894, died recently, aged 83.

Donion R. Martin, Mt. Vernon, who graduated at the Chicago Medical School in 1935, died recently, aged 45.

David Law Murphy, Dixon, who graduated at Northwestern University Medical School in 1930, died September 30, aged 50, of coronary occlusion.

Stella Henrietta Napieralski, Hinsdale, who graduated at Chicago College of Medicine and Surgery in 1916, died in Hinsdale Sanatarium and Hospital, October 23, aged 58, of burns suffered when her clothing caught fire as she was raking leaves in her yard.

Melvin Max Newman, Chicago, who graduated at the University of Illinois College of Medicine in 1924, died in South Chicago Hospital, September 6, aged 55, of coronary thrombosis.

Peter Paul O'Connor, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died December 11, aged 60, in Columbus Hospital. He was on the surgical staff at Henrotin Hospital for many years.

John J. Rendleman, Cairo, who graduated at the University of Tennessee College of Medicine, Memphis, in 1885, died October 11, aged 89, of hypostatic pneumonia and cerebral thrombosis.

Edward H. Robinson, retired, Lawrenceville, who graduated at Missouri Medical College in 1880, died November 30, aged 94.

Charles A. Sima, Oak Park, who graduated at the University of Illinois College of Medicine in 1913, died December 9, aged 64. He was on the staff at St. Anthony's Hospital more than 30 years.

Jesse C. Sutherland, Sparta, who graduated at the University College of Medicine, Richmond, (Va.) in 1907, died November 8, aged 71.

William Crowell Van Benschoten, Chicago, who graduated at Northwestern University Medical School in 1896, died October 21, aged 82, of bronchopneumonia and Parkinsonism.

COUNCIL MEETING (Continued)

component societies of this requirement, and to tell them the Society cannot accept dues in 1953 for any physicians who have not acquired full citizenship.

The list of candidates for Emeritus and Past Service-Retired membership were approved. All bills as audited by the finance committee were approved and the secretary instructed to pay them. Chairman announced next meetings of the Council, December 14, January 11, March 8, April 26, these being the regularly scheduled meetings before the annual meeting in May. By proper action, the Council adjourned at 3:10 P.M.

Harold M. Camp, M.D.
Secretary

DON'T EAT IT, WALK ON IT

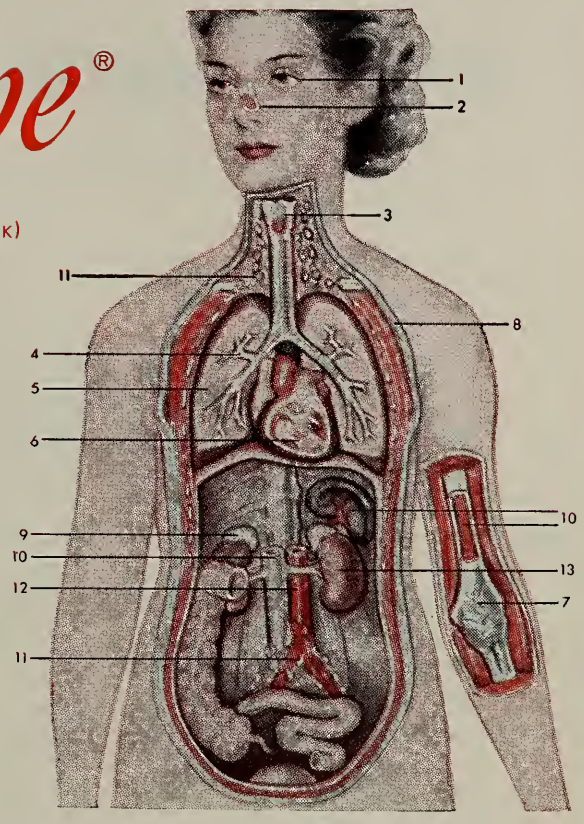
Blackstrap molasses, according to Restaurant Management, has a new use — as an ingredient in a paving material developed for the Marines. The recipe, nowhere to be found in the works of Gaylord Hauser, consists of the "wonder food" plus fuel oil, blended with sand or gravel. This yields material hard enough for military equipment to use during amphibious landings. *J. Am. Dietet A. Oct. 1952.*

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†Transient beneficial effects.

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



HEATING THE KNEE JOINT

H. M. Whyte and S. R. Reader. In ANNALS OF THE RHEUMATIC DISEASES, 11:1:54, March 1952.

It is generally conceded that radiant heat is less effective than diathermy for heating joints. Whyte and Reader have made some observations on this point in the knee joint in the course of other studies and have presented their methods and results which may be of value to those who are interested in measuring joint temperatures and assessing the effectiveness of treatment.

Three methods of heating were used in the study: long infra-red radiation, short infra-red radiation, and diathermy, the latter proving to be the best method for heating the knee joint. The fact that diathermy caused the joint temperature to rise above the normal temperature of blood is an indication of deep penetration by this form of heat. On the other hand, the delayed and poor response to radiant heat can be interpreted to mean that infra-red radiation, even of the most penetrating type such as that given by a tungsten filament lamp, has no direct effect on the joint. When radiation is applied to the knee the heat is absorbed by the skin and superficial tissues and is carried away by the blood without directly influencing to any appreciable extent the temperature of the underlying joint. However, the absorption of heat and the consequent increase in blood flow lead to gradual warming of the whole leg, as a result of which the temperatures throughout the limb, particularly in the center, approach the temperature of the blood. Therefore, the application of moderate amounts of heat to the whole limb probably is more efficient than applying intense heat restricted to the region of the joint when radiant heat, hot-water bottles, or other nonpenetrating forms of heat are used. The most that can be hoped for with these methods is to raise the joint temperature to 37 degrees C. or slightly more. The most efficient heating would be given by warming the whole limb at the same time as applying diathermy to the knee.

PHYSICAL MEDICINE AND REHABILITATION IN ACUTE MYOCARDIAL INFARCTION

Louis B. Newman, M.E., M.D., Mildred F. Andrews, B.S., P.T., Margaret O. Koblish, B.S., O.T.R., and Lyle A. Baker, M.D., Hines, Ill. In ARCHIVES OF INTERNAL MEDICINE, 89:4:552, April 1952.

This is a report of a program which involves both physical and occupational therapy which was organized and put into effect as a routine part of the management of all patients with acute myocardial infarction. This program has been in effect since June 1948 and the results have been extremely gratifying.

The first week of treatment consists of complete bed rest, with interviews by the rehabilitation staff if the patient's condition permits. The active program begins in the second week,

(*Continued on page* 39)

with the following immediate objectives: (1) To teach the patient both physical and psychological rest. (2) To instill a proper mental attitude in the patient toward his illness and to prevent the development of anxiety neurosis. (3) To return muscle tone and strength in order that the patient may be ready for physical activity. (4) To aid in prevention of peripheral circulatory stasis which is conducive to phlebothrombosis. (5) To help the patient understand his physical limitation and how to control his activities during convalescence and after discharge. The patient is given supervised exercises, including diaphragmatic breathing exercises, which are gradually increased in the third and fourth weeks. Progressive walking is started in the fifth week, and during the sixth week is increased to include stair climbing. Ambulation thus is accomplished with less physiological disturbance and apprehension, and strength and endurance are recovered more rapidly. It also has been noted that the incidence of anxiety neurosis following recovery from acute myocardial infarction is much less.

Since this program was initiated, approximately 300 patients suffering from acute myocardial infarction have been managed accordingly. For the most part, the response and cooperation of the patients to this program have been gratifying. Acceptance has been stressed by Grayson as of great importance in the success of any rehabilitation venture. Among patients suffering from acute myocardial infarction, this factor is rarely lacking. On occasion a patient, because of lack of sufficient insight, may consider the conservative, slowly progressive activity as ridiculous and may resent the close supervision. Rarely, resentment of the patient toward the misfortune of his illness may be so great that it is impossible to create any interest on his part in rehabilitation. In the majority of such cases, however, the program seems to be the most successful means of overcoming this particular mental attitude. Generally the patients welcome and are appreciative of the close attention, encouragement, and progressive nature of the program. It does much to offset the monotony, as well as giving them an objective means of measuring their progress through increasing physical activity.

The rehabilitation program contributes to more satisfactory recovery and adjustment on the part of the patient. Whenever possible, patients who should not return to their former type of occupation are seen by the vocational advisor regarding new employment. If the need arises, a social service worker should evaluate the home situation. Both the physician and the patient will have a much clearer concept of the patient's physical and mental capabilities, resulting in more objective and realistic plans for the future.

RECENT ADVANCES IN PHYSICAL THERAPY APPLIED TO GENERAL PRACTICE

Arthur M. Pruce, M.D. In THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, 41:7:305, July 1952.

Recent advances in physical therapy afford a solution to the problem of offering patients adequate office treatment at a reasonable cost during this period of inflated values. Although recent rulings of the Federal Communications Commission has left many with the problem of providing an adequate substitute for short wave diathermy, there are many physical therapy modalities which will cover the therapeutic needs of the patients.

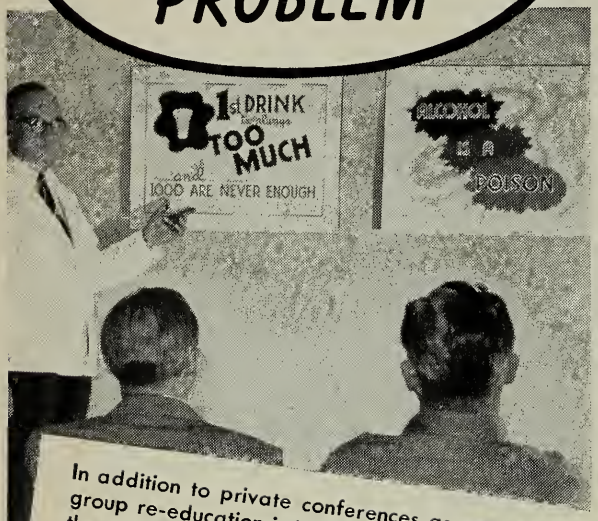
A simple, inexpensive and effective heating unit, the moist heat pack, can be used in the office and also by the patient at home. Pruce no longer considers the diathermy the basic heat unit for general practice. The moist heat pack is particularly effective in muscle spasm associated with acute lumbo-sacral sprains. The painful lumbo-sacral segment is protected against motion by lumbar muscle spasm. Office diathermy releases spasm leaving the part unprotected. Recurrence of spasm is frequently evident by the time the patient reaches his home. A more reasonable procedure would be to institute heat treatment at home. Bed rest with frequent applications of the pack will gradually restore the muscles in spasm to normal length.

There are specialized situations for which the moist heat pack, despite its adaptability, falls short in its effectiveness. The paraffin bath is the treatment of choice for chronic arthritic hands and feet, and it is essentially a home procedure.

Qualified physical therapists are not available

(*Continued on page* 40)

The Treatment of
ALCOHOLISM..
A MEDICAL
PROBLEM



In addition to private conferences as needed, group re-education is indispensable in leading the patient back toward total abstinence.

The concept of alcoholism as a medical problem, now generally accepted, is basic in the successful control of the "problem drinker."

At The Keeley Institute the therapeutic regimen is formulated on this premise. Specialized care of the individual patient rests in the hands of a highly experienced staff of physicians who supervise every step of the patient's progress.

Aversion treatment is not used, nor is restraint employed. Rather, the patient is aided toward rehabilitation through highly coordinated diet therapy, re-education, exercise and pleasant activities in an environment conducive to wholesome normal living—all under careful medical supervision.

The referring physician is kept informed of the patient's progress and receives a summary of the case upon the patient's dismissal.

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Physical Medicine (Continued)

to meet all the demands for such services. Massage applied by such trained technicians has a sedative and relaxing effect and serves as an ideal preparation for therapeutic exercise. Recently a portable electrical muscle stimulator (Medcolator) has been accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association that can reproduce certain effects of manual massage and passive exercise. This device will enable the general practitioner to administer such therapy at the bedside, or in the office with routine office help. Pruce has found the device useful in stimulating atrophic muscles at joints that have been damaged by trauma or arthritis, and also in eliciting painless contractions in flaccid paralysis. While this unit has specific properties, the value of manual massage and exercise remains undiminished.

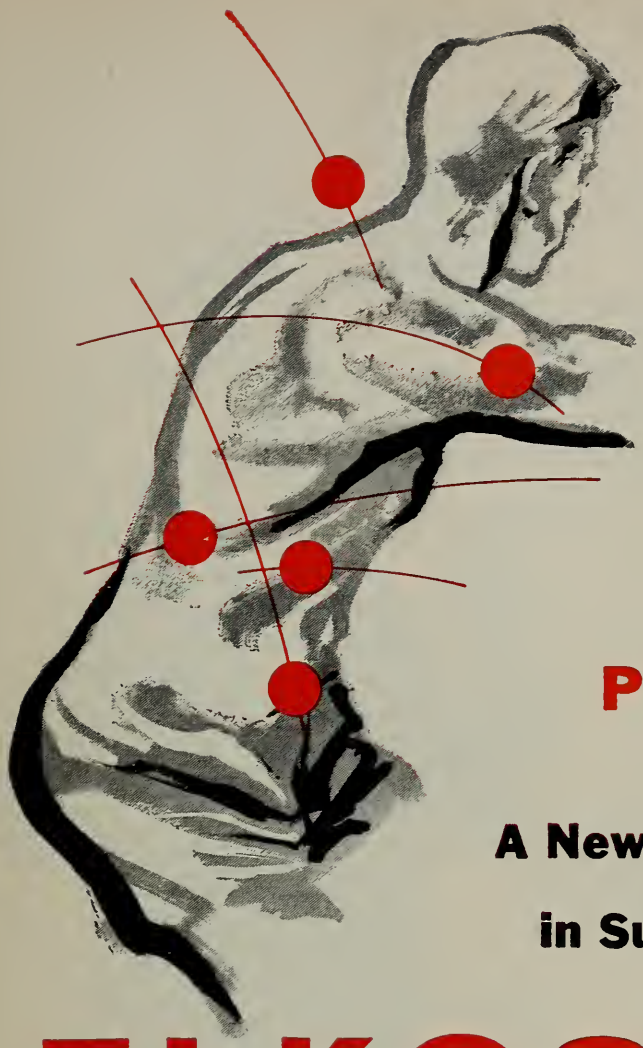
PREPARATION FOR CHILDBIRTH BY PHYSIOTHERAPY

Helen M. Nicholson, M.C.S.P., C.P.A., and George A. Simpson, M.D., C.M., F.R.C.O.G., F.A.C.S. In THE CANADIAN MEDICAL ASSOCIATION JOURNAL, 67:2:145, August 1952.

An approach has been made to the problem of helping civilized woman to meet the difficulty of childbirth through her own understanding and cooperation. The aims underlying this treatment are three: (1) the reduction of fear; (2) the promotion of relaxation; and (3) the maintenance of good body mechanics.

The reduction of fear is brought about by a discussion of an outline of the physiology and mechanics of pregnancy and labor. The most efficient results in reducing the sensations of pain are obtained through mental and physical relaxation. The patient should be attended, during her confinement, by someone conversant with it herself and with the relaxation procedure which she has been taught during her pregnancy. Patients are not told that relaxing will make the process painless, but rather that the contractions will not reach a degree of intensity beyond their tolerance. As a result, those with excellent relaxation are delighted with their success while those less successful are not disappointed. At no time is it suggested that sedation be with-

(*Continued on page* 40)



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held or that anesthesia in the second stage of labor is not the accepted procedure.

The promotion of relaxation is taught with patients lying on a hard surface, upon which it is easier to obtain a more complete understanding of the relaxed state. Deep breathing is tiring and inhibits full relaxation, if prolonged. A feeling of deep relaxation usually takes quite a considerable time to be appreciated but, once achieved, practice should be directed at reaching this condition as soon as possible. The next step includes achieving this relaxation under unfavorable conditions, such as a radio playing too loudly on a distasteful program. The body must also be trained to remain relaxed while the mind is actively occupied in listening to a conversation or to a program, so that visits by doctors and nurses during labor will be less likely to spoil the continuity of the relaxation rhythm. It is important also that relaxation may be achieved in positions other than on the back.

The maintenance of correct muscle balance and of individual control of muscle groups of the abdominal back and pelvic floor muscles is of paramount importance. A patient has little hope of being able to relax and to cooperate in the later stages of labor if the latter has been neglected. A few very simple exercises are all that is required to allow the spine to remain flexible, allow walking with the least difficulty and permit the patient to relax and move to or from any position, even at full term. It cannot be overstressed that the greatest hindrance to correct posture and muscle balance during pregnancy is the wearing of a maternity corset, unless secondary symptoms are deemed by the physician to warrant its prescription.

An analysis of the record of one hundred and ten patients treated by this method shows a reduction in the length of labor and hospital stay. The amount of analgesics required by the patients has not been greatly decreased, although by their own reports, some were given sedation prior to their immediate need or wishes. However, it seems to those of the medical and nursing staff with whom the matter has been discussed that patients practicing relaxation are more controlled, quieter and much more cooperative. This in itself is a definite point in favor of these techniques.

(*Continued on page* 44)

Octin - *for Relief of Smooth Muscle Spasm*

Octin is an antispasmodic with both neurotropic and musculotropic action indicated for the treatment of smooth muscle spasm, particularly in spastic conditions of the genitourinary and gastrointestinal tracts. It acts promptly and the relaxation usually lasts three to five hours.

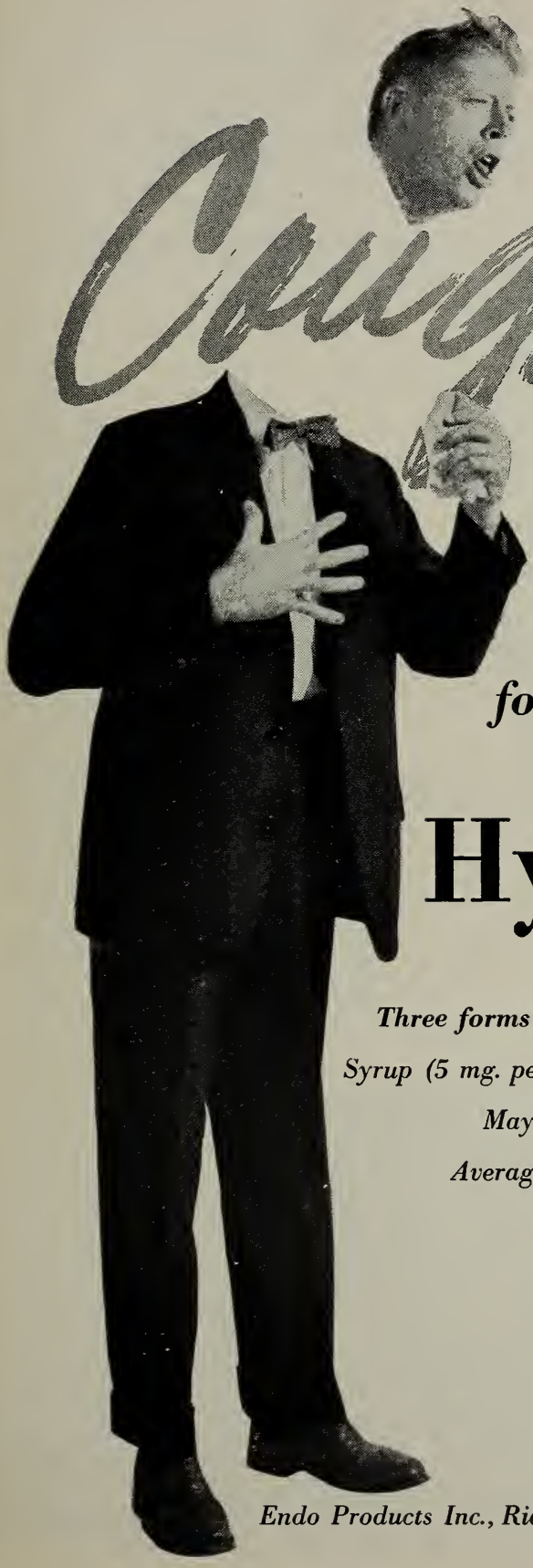
DOSE: Orally, one tablet (2 grains Octin mucate) every three to five hours.

Intramuscularly, ½ to 1 cc. (1 cc. ampule, 0.1 Gm., Octin HCl.) every three to four hours.



Octin, methylisooctenylamine, Trade Mark Bilhuber.

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May be habit forming; narcotic blank required.

Average adult dose 5 mg. Literature on request.

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Physical Medicine (Continued)

Although a short involuntary relaxation and relief may be gained by the patient if she follows the physician's instructions to take short breaths or to scream, she is usually not recipient to the command to relax, having no knowledge of how this may be achieved, unless she has received prior training. Such training is the aim of this program, in which it is attempted to prepare pregnant women beforehand, to interpret and cooperation with the physician's requests. It is regrettable, therefore, that so many physicians do not avail themselves of this successful program and of the services of physical therapists in administering it.

CONVALESCENCE AND REHABILITATION

Murray B. Ferderber, M.D. In THE PENNSYLVANIA MEDICAL JOURNAL, 55:7:669, July 1952.

This report is intended to assist those physicians who live in areas without hospital services or departments of physical medicine. It is a compilation of simple but practical measures devised by surgeons and internists who have used these ideas to hasten the period of convalesence to a successful conclusion.

Simple bed exercises such as quadriceps settings will help to maintain strength in the largest muscle of the body. Ferderber describes a simple device for increasing strength and range of the thigh muscles which can be made from inexpensive materials—clothesline and belting.

Despite any advertised claims, heat is used for one purpose only—the production of hyperemia. Ferderber discusses the uses of heat in many injuries and conditions. Heat is especially useful in the treatment of hand injuries; washing dishes and wringing cloths in hot water will supply the moist heat and exercise so necessary for resolution of such disability. He also discusses the care of patients confined to bed for long periods of time. Disuse atrophy can be lessened by bed exercises which in turn will reduce demineralization of bones in long-standing cases.

(*Continued on page* 46)

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Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

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Also available with ¼ gr. phenobarbital.

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Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Loss of nitrogen cannot be prevented; however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect.[3]

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[1] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

Knox Gelatine is easy to digest, while its supplementary dietary nitrogen will furnish protein without other substances, especially salts of potassium which are retained during convalescence; without excess fat and carbohydrate, which are not needed especially; and without a food volume which may interfere with intake.

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.



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Physical Medicine (Continued)

Ferderber cautions that the limb-maker possesses neither the professional background nor the training to teach an amputee gait-training. A qualified physical therapist with amputee training can and will prevent improved walking which is undesirable and does not approximate the normal gait.

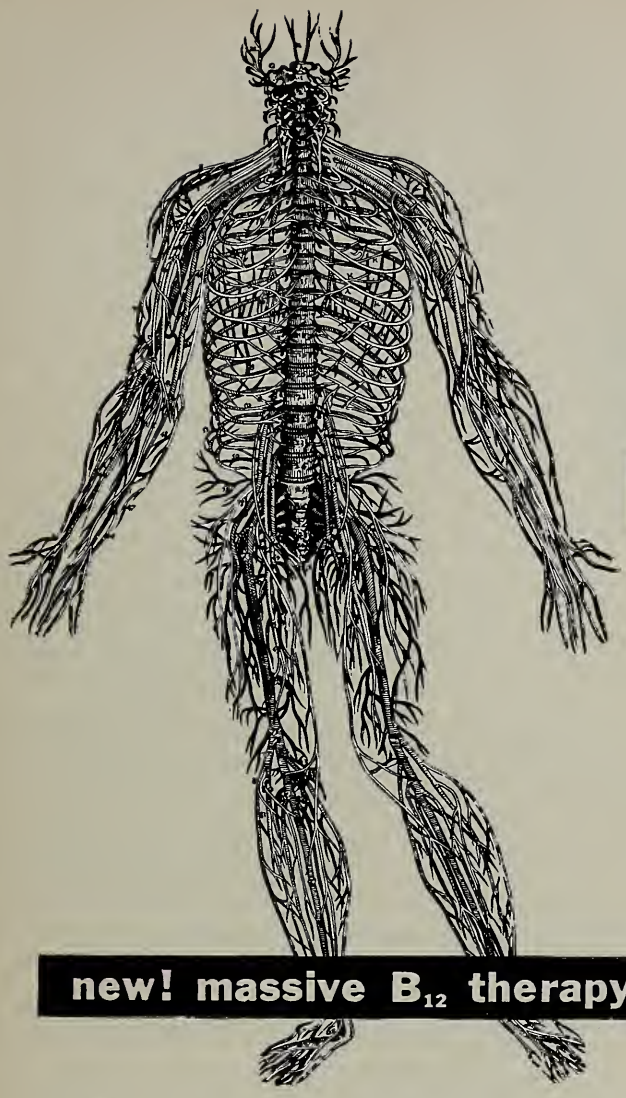
THERAPEUTIC APPLICATION OF ULTRASONIC ENERGY

Fritz Friedland, M.D., John G. Bisgrove, M.D., and Bernard J. Doyle, M.D. In ARCHIVES OF PHYSICAL MEDICINE, 33:8:461, August 1952.

During the period from June 1950 to June 1951, 161 cases (141 patients) were given 1477 ultrasonic treatments. Because of the physical properties of ultrasonics the authors chose for their studies out of a vast variety of indications suggested in the literature such conditions as those in which heat and massage have always been considered beneficial. In order to evaluate the therapeutic results, an attempt was made to answer the following three questions: (1) Is there any damaging effect of ultrasound? (2) Is there any beneficial effect? (3) Is the beneficial effect of ultrasound greater than that of other therapeutic agents? Since no significant detrimental effects were observed in 1477 applications, the authors believe that the answer to question (1) is a confirmation of the statements in the literature, namely, that ultrasonic therapy can be considered safe therapy. In order to answer questions (2) and (3), the observations made on their patient material were compared with those made on a similar group of control cases treated with conventional physical therapy. The findings suggest that ultrasonics has a pain relieving effect which apparently is equal to the analgesic effect of other physical agents such as infra-red and diathermy. Individual cases were discussed to illustrate these results. No claim could be made of any other curative effect, and ultrasonic therapy was considered local therapy which cannot be expected to influence the etiological background of the conditions treated.

The chief advantage of ultrasonic therapy consists in its relatively easy application and the short duration (4-10 minutes) of the treatments. Experience has shown that often a

(*Continued on page* 48)



dramatic,
sustained relief
in
severe

nerve pain

of

- trigeminal neuritis
- diabetic neuritis
- subacute combined sclerosis (of pernicious anemia)
- peripheral neuritis
- herpes zoster
- tabes dorsalis

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Physical Medicine (Continued)

change from one physical agent to another will be followed by improvement in cases which previously failed to respond to therapy. For this reason, ultrasonics is a welcome new therapeutic modality. However, we believe that many years of combined efforts in physical medicine will be necessary to come to a final conclusion on the therapeutic possibilities of ultrasonics in medicine.

REHABILITATION OF PERIPHERAL NERVE INJURIES

John H. Aldes, M.D., Arthur C. Bockstahler, Lionel Lieberman. In ANNALS OF WESTERN MEDICINE AND SURGERY, 6:7:418, July 1952.

Rehabilitation of peripheral nerve injuries begins at the time of admission for primary treatment. The length of delay in starting rehabilitation is in direct proportion to complications which arise. Contractures, joint stiffness, and resulting deformities are greatly minimized when treatment is begun early.

The rehabilitation team, which includes the patient, must have a thorough knowledge of the program, and the expected goal of the patient's vocational and social activity.

The scope of the treatment is limited by several factors; among these is the nature of the lesion in the nerve which has a fundamental influence upon the degree of recovery.

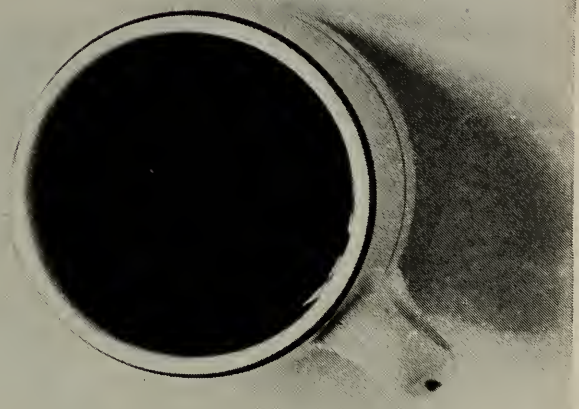
Prevention of contractures of muscles and soft tissues and secondary changes in joints must be a goal in the rehabilitation program.

The final success of treatment is in the hands of the patient, who must realize that without regular daily use of the affected limb in his vocational and social activity, best functional results cannot be obtained.

Because the control of tuberculosis is a universal problem, found in all areas everywhere, the program must be shared by all agencies working together, official and voluntary. This means that the disease must be found, isolated, and treated and that efforts and methods for control must transcend the boundaries of a single state, local area, state or nation. The cost of fighting tuberculosis is very great and the problems it produces are many and complex. . . Efforts to control it and eventually to eradicate it require most intensive work on local, state, national and even international levels of action. Mabel Baird, Conn. State Med. J. May, 1952.

For the nervous patient

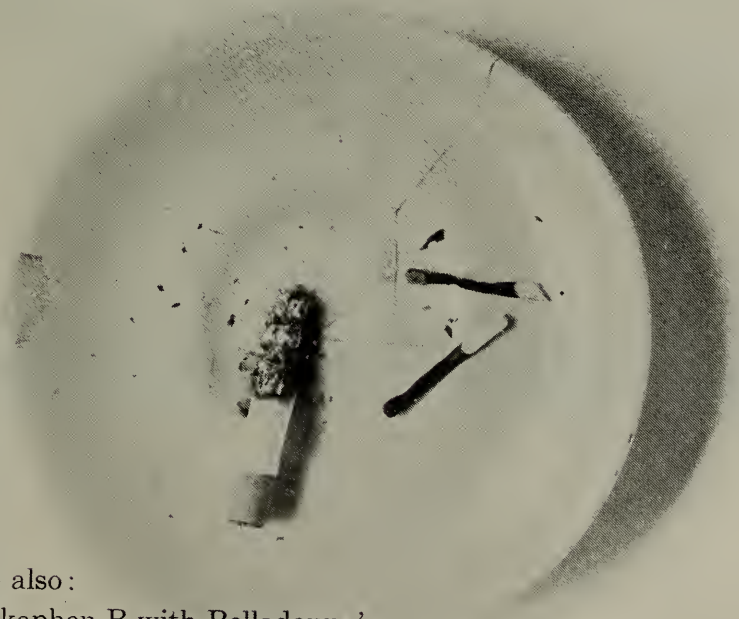
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BOOK REVIEWS



THE TREATMENT OF INJURIES TO THE NERVOUS SYSTEM. By Donald Munro, M. D. F. A. C. S. Surgeon in chief, Dept. of Neurosurgery. The Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine; Assistant Professor of Neurosurgery, Harvard University Medical School. Published by W. B. Saunders Company, Philadelphia, London. 1952 Price $7.50.

This book is not large, only 284 pages and is written by an eminent neurosurgeon for the use primarily of the general surgeon and the general practitioner. Cognizance is taken of the "obvious fact that the bulk of neurologic surgery lies in the field of trauma and not in the field of tumors."

More than one half of the volume deals with the general consideration of trauma to the nervous system and its many and wide complications. And, this is considered in minute and specific detail as to the correct therapy for each condition that may be present. For instance the portion dealing with spinal puncture is very lucid in its explanation of the result of its use. The dangers of puncture, following trauma, or contra-indications are vividly set forth, and in terms easily understood and well emphasized. Again, the technique for care of body functions is minutely described and made extremely interesting by depicting the physiological reasons for such care. Practically all questions of care, and the alerting of the medical attendant as to progress of the complication that may be present or developing is set forth. And are told with very direct statement and no verbosity. The consideration of the respiratory system as affected primarily by injury of the brain or cord, and by concurrent complications is most complete. Reasons for suction in respiratory complications are given and at the same time is established how one is to establish relief by treatment of the original injury and very shortly thereby eliminate the need for such mechanical aids. Many other symptomatic therapies are explained and means for their discontinuance outlined.

The second half of the volume deals with treatment of other specific portions of the nervous systems, such as the cranial nerves, injuries to spinal roots, injuries to the peripheral nervous system, injuries to the autonomic nervous system, etc.

The effect of anesthesia on the central nervous system has adequate space.

Emergency surgery, applicable to all possible types of injuries of the nervous system is detailed. The indications, the contra-indications and the definite types of surgery are explained.

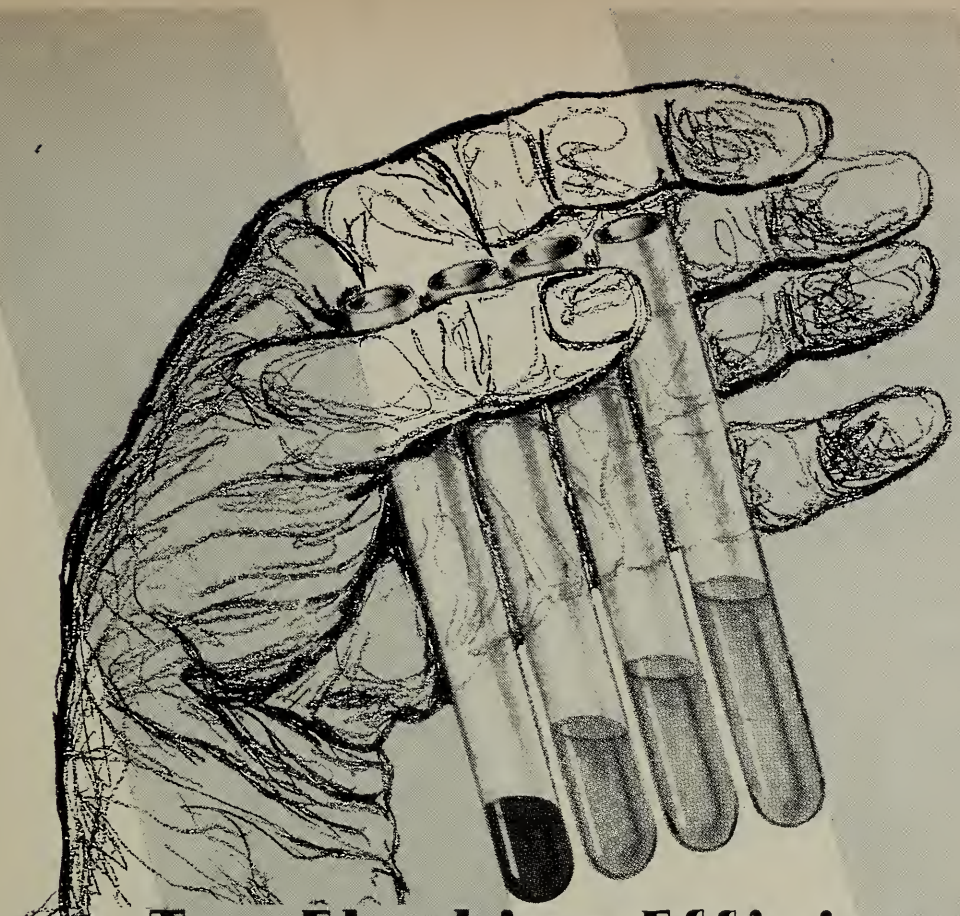
"Rehabilitation" receives consideration and the actual practical procedures are portrayed. As elsewhere all through this book, the text is not cluttered up with this and that method that may have been promoted by various writers, even well known surgeons, but that method which has proven efficient and withal practical is laid down and the wherefore made plain.

The book is very readable, and surprisingly interesting. It is very adaptable as an immediate reference because of its extensive table of content and its index.

A TEXTBOOK OF ORTHOPEDICS with a Section on Neurology in Orthopedics; by M. Beckett Howorth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School. In association with: Fritz J. Cramer, M.D., Donovan J. McCune, M.D., A. Wilbur Duryee, M.D., J. William Littler, M.D., Walter A. Thompson, M.D. 1110 pages with 463 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $16.00.

Doctor Howorth, from his vast experience in the practice and teaching of orthopedics, has produced a

(*Continued on page* 54)



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Natural bile or unconjugated bile salts	Choleretic	Stimulates secretion of normal bile by the liver	++	Utilizes increased amounts of bile of normal viscosity
Dehydrocholic acid	Hydrocholeretic	Stimulates secretion of fluid bile by the liver	+++	Utilizes copious amounts of free-flowing bile – adequate in absence of spasm of sphincter of Oddi
Dehydrocholic acid, homatropine methylbromide, phenobarbital (CHOLAN HMB)	Hydrocholeretic, parasympatholytic, sedative	Stimulates secretion of fluid bile by the liver, and relaxes sphincter of Oddi spasm	++++	Utilizes copious amounts of free-flowing bile and relaxes smooth muscle spasm for greater therapeutic efficacy

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BOOK REVIEWS (Continued)

unique textbook on the grand scale of a keen scholar.

His introductory chapter gives a brief but comprehensive history of orthopedics and the pioneers who founded the basic principles upon which this dynamic specialty has been built. However, in addition each chapter incorporates a short history of the special topic under discussion.

Doctor Howorth has not compiled a handbook of orthopedic technics but has presented a study of the diseases and abnormalities of the neuro-muscular system on a broad biological foundation with a consideration of the patient as a dynamic whole as well as of the local condition.

The etiological bases of orthopedic abnormalities is thoroughly explored when known and stimulating to further study and investigation. His anatomic approach is dynamic, from the skin inward using the living subject as the model for demonstrating the anatomic features which can be seen and felt from the surface-in motion as well as at rest.

Posture is considered as the body motion, dynamic posture and not as static posture. This is of prime consideration in orthopedics.

Special attention is given to disorders of the spine, hand, knee and foot. The special chapter on the diseases of the nervous system which effect the neuro-muscular systems was prepared by Doctor Fritz Cramer.

J.W.P.

PHYSICIAN'S HANDBOOK by Marcus A. Krupp, M.D. Assistant Clinical Professor of Medicine, Stanford University School of Medicine, Director, Palo Alto Medical Research Foundation, Palo Alto. Norman J. Sweet, M.D., Assistant Professor of Medicine, University of California School of Medicine, San Francisco. Ernest Jawetz, Ph.D., M.D., Associate Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco. Charles D. Armstrong, M.D., Clinical Instructor in Medicine, Stanford University School of Medicine. Seventh Edition, Lange Medical Publications, University Medical Publishers, Post Office Box 1215, Los Altos, California.

The 7th Edition of this useful handbook presents many changes and improvements. To those who are not familiar with this book, it is designed to render quickly factual data, laboratory procedures and clinical aids repeatedly used in all branches of medicine.

The new edition combines pithy, dogmatic discussions in each of its thirty chapters with charts, diagrams and listings of specific facts.

A clever, simple, and rapid index is incorporated on the first page and, of course, a complete index is found in the back of the book.

This book will prove invaluable for every student and practicing physician.

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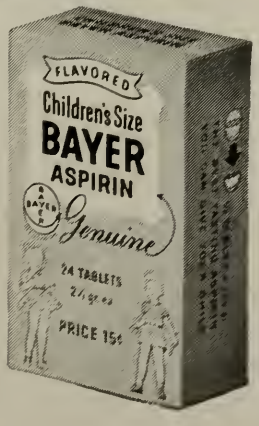
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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Operating Room Technic: By St. Mary's Hospital, Rochester, Minnesota. New, 4th Edition. 345 pages with 219 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $6.50.

Emergencies in Medical Practice. Edited by C. Allan Birch, M. D., F. R. C. P., Physician, Chase Farm Hospital, Enfield. 143 illustrations, 15 in colour. Third Edition. E. & S. Livingstone Ltd., Edinburgh and London, 1952. Price $7.00.

Side Effects of Drugs. By L. Meyler, Consulting Physician at Groningen (Netherlands) Translated by Ph. Vuijsje and W. Mulhall Corbet, Amsterdam. Elsevier Publishing Company, Amsterdam, Houston, London, New York. Price $5.50.

The Principles and Practice of Medicine, A Textbook for Students and Doctors. By L. S. P. Davidson, B. A. Cantab, M. D., F. R. C. P. Ed., F. R. C. P. Lond. M. D., Oslo, Physician to H. M. the Queen in Scotland, Professor of Medicine and Clinical Medicine, University of Edinburgh, Physician, Royal Infirmary, Edinburgh, and The Staff of the Department of Medicine and Associated Clinical Units. E. & S., Livingstone Ltd., Edinburgh & London. Price $6.75.

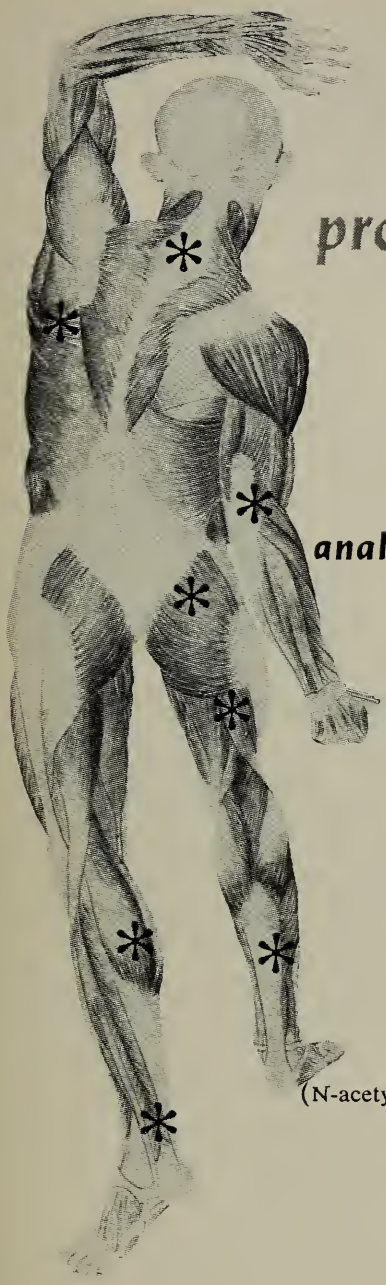
Diseases of the Skin, A Manual for Students and Practitioners. First compiled by the late Robert W. MacKenna, M. A., M. D., Ch. B. (Edin.) Fifth Edition by Robert M. B. MacKenna, M. A., M. D., (Camb.), F. R. C. P., London. With a chapter concerning radiology by I. G. Williams, F. R. C. S. (Eng.), D. M. R. E. (Camb.), F. F. R. (Gt. B.) Bailliere, Tindall and Cox, 7 and 8, Henrietta Street, Covent Garden, W. C. 2. $8.00.

Rheumatic Diseases, Diagnosis and Treatment. By Eugene F. Traut, M. D., F. A. C. P. 192 illustrations. The C. V. Mosby Company. $20.00.

Textbook of Surgery. Edited by H. F. Moseley, M. A., D. M., M. Ch. (Oxon), F. A. C. S., F. R. C. S. (Eng.) F. R. C. S. (C) With foreword by G. Gavin Miller, M. D., C. M., M. Sc., F. R. C. S. (C), F. A. C. S. 460 text illustrations and 46 color plates. The C. V. Mosby Company, St. Louis. $15.00.

Annals of the New York Academy of Sciences, Volume 55, Art. 4, pages 543-742. "Biology of the Testes" by Warren O. Nelson and other outstanding investigators. 200 pages, illustrated. Price $3.75.

Annals of the New York Academy of Sciences, Volume 56, Art. 1, pages 1-139. "Oral Fat Emulsions". By Frederick J. Stare and other leading investigators. 140 pages illustrated. $3.00.



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Tuberculosis is notorious for the difficulty of detecting it in its early stages. By the time it is discovered, the disease usually has been transmitted to others. In view of this fact, no method of treatment will solve the TB problem in short order, although improved methods should help hasten the far-off day of eradication of tuberculosis. A good vaccine, superior to BCG — the one most widely used at present — would have greater potentialities for rapid control of tuberculosis than any method of treatment. There is no simple solution to the tuberculosis problem. The disease, because of its infectiousness, its present prevalence, its symptomless onset, its long duration, its tendency to recur even though once arrested, is one of the most complex and costly public health problems in the United States. James E. Perkins, M.D., Annual Report of the NTA, Apr. 1, 1951 to March 31, 1952.

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Although the daily allowance of protein recommended for human beings has been established for some time,[1] only very recently has a recommended daily intake of individual essential amino acids been proposed.[2] These new criteria now give a more accurate means for nutritionally evaluating the protein contribution of meat than was possible just on the basis of the gross amount of protein meat provides.

The table which follows gives the proportions of the recommended daily intake of individual essential amino acids provided by six ounces of cooked meat, the approximate average per capita daily consumption in the American diet. Note that though furnishing about 52 per cent of the daily protein allowance for a normal adult male, six ounces of meat supplies more than the recommended daily intake for a majority of the essential amino acids and a goodly proportion of the recommended intake of the remainder.

Percentages of Recommended Daily Intake of Eight Essential Amino Acids and of Protein Contributed by 6 Oz. of Cooked Meat*

Essential Amino Acids	Beef[3]	Lamb[4]	Pork[4]
L-Isoleucine	141	121	127
L-Leucine	150	120	125
L-Lysine	202	163	172
L-Methionine	42	34	40
L-Phenylalanine	70	63	70
L-Threonine	160	169	183
L-Tryptophan	90	90	100
L-Valine	136	107	113
Protein	56	49	51

*In the calculations, averages of the percentages of protein in six different cuts of each type of cooked meat were used, as were averages of the percentages of the amino acids in the protein of the respective cuts.

Every kind and cut of meat is not only an excellent source of the essential amino acids but also of the nonessential amino acids, the B group of vitamins, iron, and other essential minerals. Morever, meat is rapidly and almost completely digested, has a stimulating influence upon appetite and digestion, and gives a gratifying sense of satiety. All these nutritional and physiologic advantages of meat fully justify its prominent place in normal diets of persons of all ages and in many special diets.

REFERENCES

1. Recommended Dietary Allowances, National Research Council, Reprint and Circular Series, No. 129, Washington, D. C., 1948.
2. Rose, W. C.: Half-Century of Amino Acid Investigations, Chem. and Eng. News *30*:2385 (June 9) 1952.
3. Greenwood, D. A.; Kraybill, H. R., and Schweigert, B. S.: Amino Acid Composition of Fresh and Cooked Beef Cuts, J. Biol. Chem. *193*:23 (Nov.) 1951.
4. Schweigert, B. S.; Guthneck, B. T.; Kraybill, H. R., and Greenwood, D. A.: The Amino Acid Composition of Pork and Lamb Cuts, J. Biol. Chem. *180*:1077 (Oct.) 1949.

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A MEDICAL PROJECT

The Commission (on health needs) has one major objective, the directive reads. "During this crucial period in our country's history, it will make a critical study of our total health requirements, both immediate and long term, and will recommend courses of action to meet these needs. The Commission is authorized and directed to inquire into and study the following:

(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators, and allied professional workers; the adequacy of this supply in terms of the present demands for service; and the ability of educational institutions and other training facilities to provide such additional trained persons as may be required to meet prospective requirements.

(b) The present ability of local public health units to meet demands imposed by civil defense requirements and by the need of the general public during this mobilization period.

(c) The problems created by the shift of thousands of workers to defense production areas requiring the relocation of doctors and other professional personnel and the establishment of additional facilities to meet health needs.

(d) The degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities.

(e) Current research activities in the field of health and the programs needed to keep pace with the new developments.

(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long range requirements of military, civil defense, veterans' and other public service programs for medical personnel and facilities.

(g) The adequacy of private and public programs designed to provide methods of financing medical care.

(h) The extent of federal, state, and local government services in the health field, and the desirable level of expenditures for such purposes taking into consideration other financial obligations of government and the expenditures for health purposes from private sources." *Paul B. Magnuson, Too Big A Job For One Year. Maryland M.J. Sept., 1952.*

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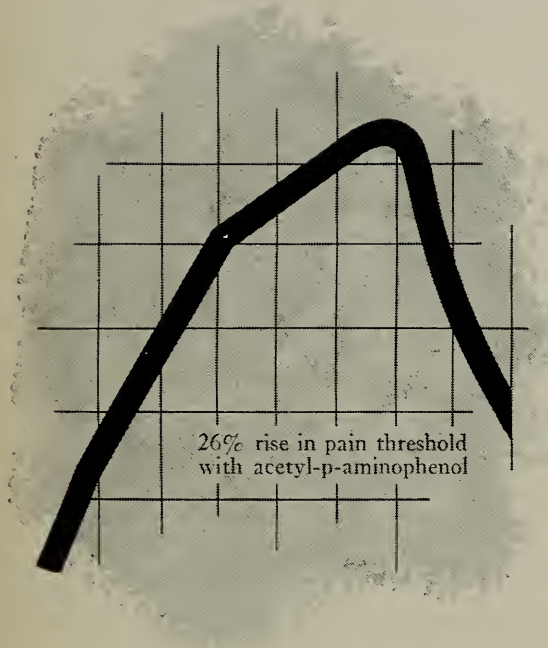
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TREATMENT OF MIGRAINE

In dealing with the tension element in these migraine patients, the most logical solution is to remove the cause of the tension. However, this is often easier said than done because in most cases the tension factor ties in with the patient's occupation, home life, age, or other factors which are not too easily changed in any complete form, although some minor adjustments can be made in most cases. Another method by which the tension factor can be combined is by a mild sedative. The ergotamine tartrate and caffeine combination has proved effective in relieving the headache phase of this problem. The addition of bellafoline to Cafergot (ergotamine tartrate and caffeine) seems to cut down the gastric side effects in some cases. Ergotamine tartrate is a sympathetic sedative and caffeine is a central stimulant. Bellafoline acts as a parasympathetic inhibitor, relieving smooth muscle spasm and controlling hypersecretion. Bellafoline has been found to be less toxic than similar drugs used at the same dosage level. *Robert E. Ryan, M.D. Headache. J. Missouri M.A. Nov. 1952.*

A recent British writer designates tuberculosis as "a disease which has no frontiers." Quarantine cannot be used against it as is possible in foci of plague, cholera or yellow fever. Segregation in sanatoria is our best substitute. But even this has its drawbacks. First there are not enough beds, second discharge against advice is still current, releasing infectious cases again into circulation. Kendall Emerson, M.D., Conn. State Med. J., May, 1952.

HORMONES IN MALIGNANCIES

Isolated cases of malignant tumors, other than those originating in the breast and prostate gland, have been known to respond to hormonal therapy. Practically all of the hormones have been used experimentally in the treatment of cancers. The newest addition to the available hormones in cortisone. Cortisone and ACTH have been used in all kinds of malignant diseases, and experimental studies have been carried out to determine whether increased adrenal cortical function would affect the rate of growth of neoplastic tissue in man. It has been shown that marked temporary regression of lymphoid tumor masses occurs in patients with chronic lymphatic leukemia, lymphosarcoma, acute lymphocytic leukemia, and plasma myeloma during the administration of ACTH and cortisone. In no patient has a complete remission of disease been obtained with the use of these hormones. Metabolic studies of patients with lymphoid tissue or lymphoid tumors have demonstrated a marked destruction of lymphoid tumor tissue and of normal tissues which occurs during the administration of ACTH and cortisone. In some cases, tumor growth actually seems to be augmented in spite of the lessening of induration and edema in surrounding tissue. The recommendation has been made that ACTH and cortisone should be avoided in the presence of malignancy. As of today, these last two agents, cortisone and ACTH, must be considered experimental and uncertain agents and should be employed as a last resort if at all. *Arthur G. James, M.D. Hormonal Treatment In Malignancy. Ohio M.J. Sept. 1952.*

Even in a community with plenty of tuberculosis beds it can hardly be expected that every patient with chronic tuberculosis and positive sputum be hospitalized indefinitely. For example, the intelligent and relatively asymptomatic elderly patient, unsuitable for additional therapy other than rest, retired on a pension and living in a home without children, can remain at home without excessive danger to himself or to others. The irresponsible bar fly, who finally persuades the tavern owner to let him wait on table or work in the kitchen to help pay for his drinks, clearly needs continued institutionalization of some type. Even where tuberculosis beds are limited, and when there is little to offer therapeutically, it is justifiable to use every reasonable means to confine such a patient to a sanatorium or hospital indefinitely. Committee on Therapy, American Trudeau Society, The American Review of Tuberculosis, May, 1952.

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Vol. 103, No. 2 February, 1953

TOO MUCH ANTI-RABIC VACCINATION

The seriousness and dread of rabies in man is well known. What many physicians seem to appreciate much less and perhaps consider too lightly is that the anti-rabic vaccination of human beings involves serious risks also. Paralysis and encephalitis as complications of sequelae of vaccination against rabies are not rare. Records in Illinois over a ten year period show a post-vaccinal paralysis rate of 1 per 2800 patients vaccinated and there is some evidence that all cases of such complications are not reported. During the ten year period, 2 patients died and the health of others was left permanently impaired from complications resulting from treatments.

The U. S. Public Health Service has estimated that the national rate of serious post-vaccinal complications is about 1 in 6,000 persons treated. Iowa is reported to have had 1 death from rabies and 3 from post-vaccinal complications during the 10 years 1940-1950.

The number of persons vaccinated against rabies in Illinois ranges from about 3,000 to 6,000 per year. It seems unlikely, in view of the risk and the expense, that such a large volume is justified. More time and consideration might well be given to the evidence on which a decision to vaccinate is based. Perhaps the most important rule to follow is to observe, for 10 days before starting the Pasteur treatment, the animal which has bitten the patient. Vaccination against rabies is not indicated if the animal lives through 10 days after the biting. Caution and careful inquiry concerning the health and character of the biting animal, particularly of dogs, should be observed prior to initiating treatment even when the animal has been killed. In short, the decision to administer the Pasteur anti-rabic treatment should never be arrived at lightly.

Vaccination of dogs against rabies on a community-wide basis is a very effective and relatively inexpensive way to reduce infection among dogs and thus decrease the risk of exposure among people as well as among livestock. The general vaccination of valuable dogs coupled with the strict confinement of stray or ownerless dogs would minimize if not entirely eliminate the need of vaccinating people against rabies with its attendant risks. The following chart was prepared by the World Health Organization as a guide to physicians for deciding when to give anti-rabic treatment.

(See chart at top of next page)

INDICATIONS FOR RABIES VACCINE TREATMENT*

Nature of Exposure	Condition of Biting Animal At Time of Exposure	Condition of Biting Animal During Observation Period of 10 Days	Decision As To Vaccine Treatment At Time of Possible Exposure
I. No lesions: indirect contact only	Healthy or rabid	Healthy or rabid	None
II. Licks: Skin or Mucosa (1) Unabraded	Healthy or rabid	Healthy or rabid	None
(3) Abraded	(a) Healthy	Healthy	None
	(b) Healthy	Clinicaly suspicious or proved rabid	**Start treatment at appearance of first suspicious signs**
	(c) Suspicious	Healthy	**Start treatment immediately; stop treatment if animal remains normal for 3 days**
	(d) Animal rabid escaped, killed, or unknown		START TREATMENT IMMEDIATELY
III. Bites	(a) Healthy	Healthy	No treatment, except if bites are multiple or face, head or neck bites; then treat as in III(c)
	(b) Healthy	Clinically suspicious or proved rabid	**Start treatment at appearance of first suspicious signs**
	(c) Suspicious	Healthy	**Start treatment immediately; stop treatment if animal remains normal for 3 days**
	(d) Animal rabid, escaped, killed, or unknown; or any bites by jackal, wolf, fox or other wild animal		START TREATMENT IMMEDIATELY

Note: Bites on the head, neck, and shoulders, deep multiple wounds, and those inflicted by wild animals involve a greater degree of risk, and patients should be treated accordingly.

*Adapted from World Health Organization Technical Report Series, 1950, No. 28.

ADEQUATE PUBLIC EMERGENCY AMBULANCE SERVICE FOR CHICAGO*

The provision of adequate public emergency ambulance service for Chicago has been a matter of civic concern since 1937. To have ambulance service available for emergency use in transporting persons injured in accidents, or suddenly stricken ill, to hospitals, first-aid stations, or their own homes, should be a community responsibility. Large cities like New York, San Francisco, Los Angeles, Cleveland, Milwaukee, and Indianapolis have demonstrated the value of such a service. Their experience indicates that it can be provided without harming the private services intended for nonemergency use.

A report, advocating the establishment of a public emergency ambulance service in Chicago, was published by a Joint Committee on Public Emergency Ambulance Service in 1940. Similar recommendations were made in 1949, in the report of the Chicago Cook County Health Survey. As a result of these recommendations, 14 ambulances were purchased and allocated to the Chicago Fire Department. Twelve of these ambulances, manned and operated by 70 firemen are routinely in service in 1952, with 2 in reserve. Nevertheless, the Police Department is still handling most of the calls for public emergency ambulance service. The Fire Department ambulances average two runs each 24 hours. Repeated spot checks indicate that, of all the patients entering Cook County Hospital by ambulance, police ambulances account for about

*Published in Jan. 15, 1953.
Proceedings of The Institute of Medicine.

85 per cent, and the Fire Department ambulances for about five per cent. This lack of utilization of the Fire Department ambulances is appalling. The cost of each run amounts to over $50 when salaries, maintenance of equipment, insurance, amortization of cost, and other essential items of expenses are included.

The Police Department gives evidence of doing a good job, in some ways, of handling emergency situations, even though working at times under extremely difficult situations. It uses a Squadrol, constructed for prisoner conveyance, which has space for a stretcher, but little in the way of equipment for the transportation of the sick and injured. The Police Department, by using its two-way radio system, has reduced the length of time between receipt of calls and the arrival of the police cars. The present method of handling accidents and emergencies, however, is a make-shift substitute for a well-equipped and well-organized public emergency ambulance service.

The subcommittee on public emergency ambulance service of the Institute of Medicine has been studying the problem. This committee believes that the present unsatisfactory situation can be remedied by the concerted efforts of a vigorous group, composed of representatives of medical and health agencies, welfare and civic organizations, and other interested groups. It expects to organize a committee of this type, whose function will be to stimulate a strong body of informed opinion about the need for adequate public emergency service in Chicago. The following objectives should be achieved:

1. Creation of a public emergency ambulance board. The members of this board, composed of outstanding civic leaders, would serve without compensation. They would be responsible to the mayor and would have overlapping terms of office. This board should have the same status as the Fire Department, Police Department, Health Department, and other city departments.
2. Provision of a unified public emergency ambulance service to operate under this board.
3. Establishment of zones throughout the city, where ambulance stations may be designated.
4. Certification, by the emergency ambulance board, of community hospitals, so that the care of emergency cases may be shared with Cook County Hospital.
5. Creation of a vigorous program of public education, which will arouse community interest and give faith to its citizens in Chicago's ability to provide a satisfactory public emergency ambulance service.

VITAMINS AND THE ILLINOIS PUBLIC AID COMMISSION*

At a recent meeting of the State Medical Advisory Committee to the Illinois Public Aid Commission, the following policy concerning the use of vitamins was advised. Action was deemed necessary because more and more physicians throughout the state are prescribing expensive vitamins without including a diagnosis of avitaminosis or other deficiency states on the usual forms of the Illinois Public Aid Commission. The Committee was informed that funds are limited and in effect that monies spent for unnecessary items may in the future deprive a recipient of much needed digitalis or penicillin. The Committee never questions the diagnosis of a physician nor does it attempt to tell him how to practice medicine or what to prescribe. All the Commission asks is that the diagnosis be in keeping with the remedies prescribed. In this regard there is no objection to giving vitamins for example to an old IPAC recipient who lives alone and neglects to eat, provided the reason is mentioned.

In general, the amount of vitamins prescribed is governed by the care with which the physician looks for evidence of avitaminosis or inquiries into the dietary history of the patient. Those who eat a well balanced diet including the essential foods rarely need additional vitamins. Beyond this, the use of vitamins depends upon the attitude of the physician toward these food supplements. The extremist believes every one needs vitamin supplements; others prescribe them as tonics or placebos. In the absence of evidence of a real need for vitamins, this represents a waste of the taxpayer's money and is poor medicine. Furthermore, the cost varies and all too

*Reports submitted before the Advisory Committee to the IPAC.

often, brewer's yeast will do as much as the more expensive B complex; and cod liver oil is an excellent source of vitamins A and D. As Dr. Hess states in the editorial to follow, concerning the needs of children along this line: "Vitamins should be obtained from the dairy, the grocery, and the market and it is only for exceptional cases that concentrates must be prescribed other than fish liver oils."

The Committee suggests, therefore, that the use of vitamins be limited to definite avitaminoses such as beriberi, pellagra, scurvy, and rickets. Vitamin B12 also is used in pernicious anemia. When evidence of dietary deficiency exists, specific vitamins may be necessary to correct night blindness, certain eye infections, loss of appetite, intestinal disorders, fissures at the corners of the mouth, oily dermatitis, sore tongue and mouth, diarrhea, neuralgia, Meniere's syndrome, migraine, weakness, sprue and related nutritional anemias, certain liver conditions such as cirrhosis, bleeding tendencies, and low prothrombin levels. There is need also for multiple vitamins in conditions that interfere with ingestion of food such as chronic gastrointestinal disorders (peptic ulcer, enteritis, or obstruction) and longstanding anorexia associated with alcoholism, neuropsychiatric disorders, and infections. Those with food allergy, loss of teeth, and on special diets may need supplementary vitamins and they are recommended occasionally in pregnancy, during lactation, and in children during periods of rapid growth. The vitamin needs are increased also during active infections especially when associated with long standing fever, hyperthyroidism, diabetes and advanced pancreatic disease. In diabetes, for example, the need stems not only from the diet but because polyuria is associated with an abnormal excretion of vitamins.

T. R. Van Dellen M.D.

Regarding children, the question was raised as to dispensing of vitamins and the following suggestions for meeting at least the minimum daily requirements for children's needs. Based largely on a large outpatient clinical experience and results obtained among the clients of the Chicago Welfare Administration. previously known as the Chicago Relief Administration during the past 18 years. The clientele of whom I will speak come from families who have or are receiving welfare aid. Digressing for the moment, I am quoting from my early experience on the staff of Cook County Hospital. Nutritional disturbances in infants and children as evidenced by rickets, scurvy, tetany etc, and intestinal and pulmonary infections accounted for most of the mortality in our wards. In many local neighborhoods in Chicago where poverty and ignorance were important etiologic factors in the development of nutritional disturbances, the same diseases were rampant.

Today in the wards of Cook County Hospital, extreme cases of rickets are rarely seen and classical cases of scurvy and tetany are so few that there is a shortage in the needs of these conditions even for teaching purposes. Quoting from the regulations governing medical services of the City of Chicago Department of Welfare, "*Therapeutic Diet* requests should be limited to inexpensive foods suitable for a low cost budget whenever possible. The Department of Welfare food budget allowance covers the cost of an adequate diet for a normal person. This allowance includes three-quarters of a quart of milk daily for each child through nine years of age; one quart for each child from ten through fifteen years; three-quarters of a quart for a girl sixteen through twenty; a quart for a boy sixteen through twenty and a pint for each adult. A set of low cost diets containing the normal diet and suggested therapeutic diets will be sent to physicians upon request."

All children under two years of age are encouraged to take a minimum of one or two teaspoonfuls of cod live oil daily and it is also available for older children where the physician thinks it is indicated without cost to the client. The discovery of the vitamins, their classification and their relationship to nutrition, both in health and in disease, must be considered one of the great contributions to medical science. It is becoming more firmly fixed in the minds of leading investigators that, except to meet specific indications, as in times of famine and certain economic upheavals, such as in war, the best method of obtaining sufficient vitamins is through a proper selection of foods. Vitamins should be obtained from the dairy, the grocery and the market, and it is only for exceptional cases that the concentrates must be prescribed other than fish liver oils. A survey of today

among the children and young adults in the same types of neighborhoods above quoted, the finest types of young adults are seen. Golden gloves, tennis, basketball, track and golf, the free use of bathing beaches in these same neighborhoods have resulted in the highest type of adolescent and adult development. (The extreme cost of vitamins today dispensed to the recipients of aid through the IPAC have brought the extravagance of our prescribing into the foreground in the hope that without curtailing help that may be indicated may result in great saving to the taxpayer.

J. H. Hess, M.D.

HABIT AND ADDICTION

We are creatures of habit.

As a psychiatrist, an old colleague of mine, wrote me recently that it is very difficult to draw a sharp line between mere habit and addiction. He suggested that if over-indulgence in a potentially harmful substance did no damage we were likely to regard it as a habit whereas if it obviously did harm we called it addiction. Perhaps instead of using the description "does no harm" we might substitute "does not interfere with normal life". There is no doubt that over-indulgence in some common ingesta, coffee for example, may in some people cause the jitters or even severe vertigo. Indeed as a young man I knew an illustrious gynecologist who could not drink even one cup of coffee because it caused him to act like an alcoholic in the garrulous stage.

Nowadays the word "problem" is often used as a qualifying adjective in describing addicts, and so much has been written about "problem drinkers" that we have almost lost sight of the fact that there are other types of "problem" people. There is, of course, statistical evidence that about one in every five regular consumers of alcoholic beverages is, for reasons not always clear, unable to curb his or her appetite for liquor. When one thinks the matter over one realizes that he knows people who seem unable or unwilling to restrain their consumption of tea or coffee, of soft drinks (especially those containing caffeine), of tobacco, of food, of their urge to work, of their craze for fast driving. Drug addiction may or may not be a comparable problem. We know tea, coffee, coke, and cigarette fiends, gluttonous eaters, speed maniacs and people who seem bent on working themselves to death.

What explains these phenomena or are there available interpretations? Can it be that they are merely a matter of habit? Certainly not always. There is no question that many of us are creatures of habit. We also know that some habits carried to excess have an underlying psychopathic basis and that there are diseases of endocrine origin, notably langerhansian and pituitary syndromes, in which excess is due to abnormal action of these ductless glands. Can it be that some harmful habituations are merely a matter of natural disposition or temperament, a quality hard to assess scientifically. Do some people continue to use certain substances to excess merely because they enjoy the effects just as one enjoys food or because they are lacking in that most important type of discipline, self-discipline. Are there pople with a constitutional affinity to addiction, as Eugene Kahn suggests, a sort of obsessive-compulsive phenomenon. We know that some excesses are stimulated by the desire to muffle the anxiety associated with these troublous times and that some excesses, such as overeating with obesity, may be inherited or the result of frustration, but we also know "problem" people in whom no such obvious explanations are present. Can it be that some gluttons have undetectable changes in a brain center which regulates hunger? There is evidence that some people overeat because they normally have an unusually high basal metabolic rate. The whole subject is intricate and problematic but perhaps not incapable in time of scientific solution.

G.B.

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THURSDAY EVENING, May 21, 1953
HOSPITALITY NIGHT
RECEPTION COMMITTEE

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Francis J. Hultgen, 9607 S. Sangamon Street, Chicago 43
M. J. Kutza, 1400 N. Long, Chicago 51
Charles Pope, 405 Deerfield Road, Deerfield
William Patejol, 5000 S. Ashland Avenue, Chicago 9
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Walter Kittler, Rochelle
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Mr. Douglas A. Thorsen, 307 N. Main Street, Rockford
David Slight, 5001 Drexel Boulevard, Chicago 15
John Wall, 7816 Euclid Avenue, Chicago 49
George Barnett, 37 N. Longcommon Road, Riverside
W. W. Sittler, 9917 S. Damen Avenue, Chicago 43
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Victor Engleman, 11333 Parnell Avenue, Chicago 28
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George Rukstinat, 8001 S. Laflin Street, Chicago 20
Robert M. Jones, 1488 Scott Street, Winnetka
Arnold U. Derman, 4753 Broadway, Chicago 40
M. M. Hipskin, 9400 S. Winchester Avenue, Chicago 20
Paul Vermeren, 4753 Broadway, Chicago 40
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J. J. Mullen, 30 North Michigan Avenue, Chicago 2
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Russell Barrett, 3526 N. Marshfield Avenue, Chicago 13
B. K. Lasarski, 10810 Prairie Avenue, Chicago 28
Warren C. Blim, 1544 Vincennes, Chicago Heights
Samuel Zakon, 5840 W. Adams Boulevard, Chicago 44
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Mr. James C. Leary, 185 North Wabash Avenue, Chicago 1, Secretary

KIWANIANS' $82,000 WILL FINANCE FIVE YEAR SPASTIC RESEARCH AT CHILDREN'S MEMORIAL

Basic problems of the deeper brain areas in cerebral palsy will be studied during the next five years at Children's Memorial Hospital in a project financed by the Illinois-Eastern Iowa District of Kiwanis International.

The research team which will carry out the work — all of whom are contributing their services — consists of Luis V. Amador, M.D., neurosurgeon; John A. Bigler, M.D., chief of staff at Children's Memorial; Joseph D. Boggs, M.D., pathologist; Douglas N. Buchanan, M.D., pediatric neurologist; George P. Guibor, M.D., ophthalmologist; John L. Reichert, M.D., pediatrician; Charles N. Pease, M.D., orthopedic surgeon; and Harvey White, M.D., radiologist, all of the Children's Memorial staff.

Advisory consultants are: Percival Bailey, M.D., professor of neurology and neurological surgery at the University of Illinois College of Medicine; Paul C. Bucy, M.D., professor of neurological surgery at the University of Illinois; Ray Snider, Ph.D., associate professor of anatomy at Northwestern University. Dr. John Hankinson, London, England, neurosurgeon, has arrived in Chicago as a resident fellow to assist in the work during the next year.

Kiwanis has set up a special Spastic Paralysis Research Foundation to administer the research funds. It is directed by a committee headed by Harry S. Himmel of Chicago, and consisting of C. Paul White, M.D., of Kewanee, Ross W. Griswold, M.D., of Litchfield, George L. Drennan, M.D., of Jacksonville, H. I. Conn, M.D., of Newman, Frank P. Hammond, M.D., and Harry R. Keiser, M.D., of Chicago, Ed Ballweg of Edwardsville and Bryant Hadley of Springfield, all past governors or lieutenant governors of Kiwanis.

On Saturday, Jaunary 10, the Kiwanis leaders and hospital and medical representatives dedicated a bronze plaque at Children's Memorial Hospital to mark the inception of the research project.

MENDOTA'S *OWN* HOSPITAL

The Mendota Community Hospital stands as a solid $500,000 testimonial to the courage and determination of a small town. The 5,000 people of Mendota, and another 7,000 neighbors who also benefit from the institution, took ten years to do the job, but they finally overcame war, inflation, materials shortages and other troubles to build the hospital they knew their community needed.

Moreover, there is not a cent of federal or state money in any part of the institution. The people of the area paid for it themselves. Probably no one in the whole community failed to contribute in some fashion, with money, work, materials, food and other services.

And the end is not yet. The committee and its 2500-member Women's Auxiliary are now planning to finish and equip the as yet incomplete south wing. But after what they have already done, that is a small task. Even then there will be no relaxation, for the hospital must be maintained, supplied and kept up to date. And these self-reliant citizens, who realize the community value of a good modern hospital, are determined to carry on permanently.

The hospital is also a memorial to the community spirit and personal leadership of the late Otto Ellingen, Mendota industrialist. It was Mr. Ellingen who sparked the ten-year drive for funds and then served as secretary-treasurer of the board of directors for six months after it opened, until his death.

The present president and treasurer of the board, H. D. Hume, who was also closely associated with the long fight, said of Mr. Ellingen:

"He was the kind of man any community is lucky to have. He wanted to leave more than he took from the community."

It was Mr. Ellingen, he explained, who kept up the spirits of other workers in the face of many discouragements and whose resourcefulness pulled trick after trick out of the bag to pile up the money needed. His death was a severe blow, but the impetus he imparted still remains.

A map will show the hospital's importance. In the northwestern corner of La Salle County, it is in the center of an area bounded by Princeton, 25 miles west, Dixon and Rochelle, 30 miles northwest and north, Sandwich, 30 miles east

and the La Salle-Peru area 16 miles south.

It thus serves an area with a radius of 15 to 25 miles and a population of about 15,000.

The hospital is a two-story and basement, concrete and ashblock structure on a seven-acre site at the intersection of Routes 51 and 52, only a short distance north of Route 34, on the western edge of Mendota.

The grounds themselves testify to the broad community participation in the project. Not only were the lawns, drives and shrubbery contributed, but the citizens themselves did the work. For instance, when a Utica firm offered gravel for the parking area, nearby farmers hauled it. The township lent heavy equipment to grade and roll it. Farmers brought their tractors to do the grading and planted the trees and shrubbery.

The hospital stands well back from the highway, giving not only a pleasant prospect, but freedom from traffic roar.

Inside, the visitor is greeted by Miss Schrei, administrator, whose pride in the institution shines behind every word of her description.

There is nothing unique about the hospital. Its plan, its appointments, its equipment, are those of many good well-designed small modern hospitals. It is rated now at 44 beds, with 14 bassinets. Its staff consists of 11 physicians, with 15 nurses. Its beds are usually full and it has an average of 25 deliveries a month.

It has two operating-rooms and the usual storage, scrub and dressing-rooms. In the maternity area, there are two delivery rooms, and the whole is carefully screened off from the rest of the building. Its laboratory is large and equipped to do all routine work. Blood is brought from Peoria. Everything is bright and clean and new.

The south wing is built but not finished inside. Its completion will add another twenty-five beds.

With all its charm and efficiency, however, the building itself does not compare in interest with the story behind it, as told by Mr. Hume.

It was in 1941, Mr. Hume says, that the movement for a good modern hospital began in Mendota. A survey was made and plans were drawn, but the war interfered, and little was done until peace came.

The original plan was for a 40-bed hospital to cost $225,000. The Mendota Hospital Foundation was created and after the war it raised much money. In 1947 the group had a site (selected by a vote of the contributors) and $250,000 in hand, but there was no material available, and prices had risen to a point where the money would build, but not equip, the hospital.

It was decided that more money must be sought and again the residents came through. But, every time they contributed, prices went up again and they had the battle for money all over again.

The contract for the building was let on April 1, 1949, and the work began. To raise the additional funds needed, as construction progressed, Mr. Ellingen organized drive after drive—and there was continuous pressure in between. The hospital's books now list its assets at $513,000.

Mr. Hume paid unrestrained tribute to the Women's Auxiliary. Each gave $1 to join, and to buy the right to work unremittingly. They bought linen and kitchen utensils. They fixed up their own headquarters in the basement, including its concrete floor and electric lights. They installed shelving for linen storage and bought an electrocautery. They sold magazines and gave dinners and bake sales. They canned vegetables — and still do. They held old-time "in-gatherings" and antique sales and bought old farm machinery for repair and re-sale. They built and sold scrap piles and traded livestock.

The men were busy, too. Every organization in or out of town pledged every cent it could spare. The Elks gave $65,000 in all as a group, and other organizations followed suit in proportion. They held tag days and sold bonds. They persuaded oldsters to remember the hospital in their wills. And they wrote to former residents of Mendota — no matter how far back their residence went — and got substantial gifts from California, New York, Ohio and Connecticut and many nearer places.

In the end the hospital was built and furnished — most of it.

That is about the story. Not many communities can match it for basic, old-fashioned, American self-reliance.

NINTH CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY

The ninth annual Clinical Conference of the Chicago Medical Society will be held in the Palmer House, Chicago, March 3-4-5-6, 1953.

Through its eight previous presentations, the annual Clinical Conference has evolved into one of the few largest and best teaching meetings in the world. The growth of the attendance, in 1952 around 6,000, reflects the devotion and energy of the men who have served on the various committees.

In addition to some 30 papers to be delivered in the 1953 Conference, the program will include a series of nine "practical demonstration" courses. This series, introduced in 1951, has proven so popular that it is being repeated on a more elaborate scale. Furthermore, each noon will see a round table discussion at luncheon. Each day's session concludes with an interesting panel discussion on clinicopatholgical problems, pediatrics, what's new or disorders of the chest. Carefully chosen scientific and technical exhibits will round out the program.

The program of papers and demonstrations as far as completed to date follows:

Tuesday, March 3

8:30 A.M. "Benign Lesions of the Breast"
Dr. Louis P. River, Clinical Professor of Surgery, Stritch School of Medicine, Loyola University

9:00 A.M. "Chemotherapy in Tuberculosis"
Dr. Robert H. Ebert, Associate Professor of Medicine, University of Chicago School of Medicine

9:30 A.M. "Some Considerations in the Recognition of Congenital Cardiac Disease"
Dr. Maurice A. Schnitker, Toledo, O.

11:00 A.M. "Plasma Expanders and Their Logical Use in Civilian Practice"
Dr. Frank W. Hartman, Pathologist and Director of Laboratories, Henry Ford Hospital, Detroit, Mich.

11:30 A.M. "Functional Diseases of the Digestive Tract"
Dr. Sara M. Jordan, Director, Department of Gastroenterology, Lahey Clinic, Boston, Mass.

1:30 P.M. "Management of Congenital Atresia of the Esophagus with Tracheal Esophageal Fistula"
Dr. Cameron Haight, Professor of Surgery, University of Michigan Medical School, Ann Arbor, Mich.

2:00 P.M. "Treatment of Urinary Infections — The Choice of Drug"
Dr. Grayson Carroll, Asst. Professor of Urology, St. Louis University School of Medicine, St. Louis, Mo.

2:30 P.M. "Pain in the Right Lower Quadrant of the Female Abdomen"
Dr. John C. Burch, Professor of Gynecology, Vanderbilt University School of Medicine, Nashville, Tenn.

4:00 P.M. "Cardiac Arrests"
Dr. Max S. Sadove, Professor of Surgery, Head, Division of Anesthesiology, Research and Educational Hospitals, University of Illinois College of Medicine.

Wednesday, March 4

8:30 A.M. "Pre and Post-Operative Care in Elderly People"
Dr. E. Lee Strohl, Associate Professor of Surgery, University of Illinois College of Medicine, Attending Surgeon, St. Luke's Hospital.

9:00 A.M. "Ectopic Pregnancy"
Dr. John I. Brewer, Professor of Obstetrics and Gynecology, Northwestern University Medical School.

9:30 A.M. "Hepatitis"
Dr. Cecil J. Watson, Professor of Medicine, University of Minnesota Medical School, Minneapolis.

11:00 A.M. "Common Errors in Dermatologic Management"
Dr. Rudolf L. Baer, Associate Professor of Clinical Dermatology & Syphilology, New York University Post Graduate Medical School, New York.

11:30 A.M. "Pitfalls in the Roentgen Diagnosis of Pulmonary Disease"
Dr. Philip J. Hodes, Professor of Clinical Radiology, Medical School, University of Pennsylvania; Professor of Radiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

1:30 P.M. "Treatment of Embolic Occlusion of Vessels"
Dr. D. W. Gordon Murray, Toronto, Ontario.

2:00 P.M. "The Problem of Glaucoma"
Dr. Arthur J. Bedell, Emeritus Professor of Ophthalmology, Albany Medical College, Albany, N. Y.

2:30 P.M. "The Use of Marsilid for the Treatment of Bone and Joint Tuberculosis"
Dr. David M. Bosworth, Director and Attending in Orthopedic Surgery at St. Luke's and Sea View Hospitals.

4:00 P.M. "Treatment of Infantile Diarrhea"
Dr. Daniel C. Darrow, Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.

Thursday, March 5

8:30 A.M. "Pitfalls in Urology"
Dr. Wm. J. Baker, Associate Professor of Urology, Northwestern University Medical School.

9:00 A.M. To be announced
Dr. Samuel M. Feinberg, Professor of Medicine, Northwestern University Medical School.

9:30 A.M. "Surgical Treatment of Lesions of the Esophagus"
Dr. O. T. Clagett, Professor of Surgery, University of Minnesota Graduate School, Rochester, Minn.

11:00 A.M. "The Indications for Surgical Treatment of Heart Disease"
Dr. Charles P. Bailey, Professor and Head of the Department of Thoracic Surgery, Hahnemann Medical College and Hospital of Philadelphia.

11:30 A.M. "Management of the Patient with a Solitary Mass in the Lung"
Dr. C. Allen Good, Associate Professor of Radiology, University of Minnesota Graduate School, Rochester, Minn.

1:30 P.M. "Human Anxiety and its Effects"
Dr. Roy R. Grinker, Director of Institute of Psychosomatic & Psychiatric Research and Training, Michael Reese Hospital.

2:00 P.M. "Clinical Manifestations of Hyperthyroidism with Emphasis on Frequently Unrecognized Features"
Dr. Elmer C. Bartels, Boston, Mass.

2:30 P.M. "Classic Syndromes of Brain Tumor"
Dr. John E. Scarff, Professor of Clinical Neurological Surgery, Columbia University College of Physicians and Surgeons, New York.

Friday, March 6

8:30 A.M. "The Treatment of Diabetes Mellitus"
Dr. Arthur R. Colwell, Irving S. Cutter Professor and Chairman of the Department of Medicine, Northwestern University Medical School.

9:00 A.M. "Immunization Procedures for the Child"
Dr. John L. Reichert, Asst. Professor of Pediatrics, Northwestern University Medical School.

9:30 A.M. "The Pigmented Nevi and Their Relationship to Malignancy"
Dr. Eugene F. Traub, Professor of Dermatology, New York Medical College, New York.

11:00 A.M. "Diagnosis and Treatment of Cancer of the Neck"
Dr. John J. Conley, Chief, Head and Neck Service, Pack Medical Group and Chief, Head and Neck Service, St. Vincent's Hospital, New York.

11:30 A.M. "Blood Reactions to Various Drugs"
Dr. William Dameshek, Professor of Clinical Medicine, Tufts College Medical School, Boston, Mass.

1:30 P.M. "Gynecological Symptoms of Major Importance to the Physician in General Practice"
Dr. V. S. Counsellor, Head, Section of General and Gynecological Surgery, Mayo Clinic; Professor of Surgery, University of Minnesota Graduate School, Rochester, Minn.

2:00 P.M. "Hypertension and Drugs"
Speaker to be announced.

2:30 P.M. "Foreign Bodies in the Air and Food Passages"
Dr. Paul Holinger, Professor (Bronchoesophagology) Dept. of Otolaryngology, University of Illinois College of Medicine.

DEMONSTRATIONS

NEUROLOGY CLINIC: Dr. Benjamin Boshes, Associate Professor and Chairman of Nervous and Mental Diseases, Northwestern University Medical School.

DERMATOLOGY CLINIC: Dr. Herbert Rattner, Professor and Chairman, Department of Dermatology, Northwestern University Medical School.

FRACTURE CLINICS:
"Upper Extremities" Dr. James K. Stack, Associate Professor of Bone and Joint Surgery, Northwestern University Medical School.
"Lower Extremities" Dr. James J. Callahan, Professor & Chairman, Department of Bone and Joint Surgery, Stritch School of Medicine, Loyola University.

OBSTETRICS & GYNECOLOGY: Dr. Frederick H. Falls, Professor and Head, Department of Obstetrics and Gynecology, University of Illinois College of Medicine.

FLUID & ELECTROLYTE BALANCE IN SURGERY: Dr. John T. Reynolds, Clinical Associate Professor of Surgery, University of Illinois College of Medicine.

RADIOLOGY: Dr. Warren W. Furey, Asst. Clinical Professor of Roentgenology, Stritch School of Medicine, Loyola University.

TUMOR CLINIC: Dr. Danely P. Slaughter, Director of Tumor Clinic; Associate Professor of Surgery, University of Illinois College of Medicine.

REHABILITATION CLINIC: Dr. Frances Hellebrandt, Head, Department of Physical Medicine and Rehabilitation, University of Illinois College of Medicine.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



The V. A. Hospital and the Private Physician

Roland R. Cross, Jr., M.D.

Chicago

To a large number of people, physicians included, the Veterans Administration Hospital is a large vaguely defined thing that seems somewhat incomprehensible. Part of this is due to its size and part due to the feverish activity of the times where each citizen is so busy with his own job that he really hasn't taken time since 1940 to stop and think about this activity. Many items come up and the hurried, harried individual in an exasperated manner shrugs his shoulders with a meaning of what can be done with such a big impersonal thing. This is especially true of physicians who have patients that want to go to a V. A. Hospital or who have returned from one desiring their private physician to continue the care instituted at the hospital.

The United States has had a program for the care of its veterans even from before the Revolutionary War. At the end of World War I however, the veteran population had increased to such an extent that the system of veterans care began to fall apart. As a result of the findings of a special commission, congress in 1921 combined all the veteran activities of the Bureau of War Risk Insurance, the Federal Bureau for Vocational Education, and the U. S. Public Health Service into the one agency — the Veterans Bureau. In 1930 it was further combined with the Pension Bureau and the National Military Home Service to form the Veterans Administration. One division of the Veterans Administration is the Department of Medicine and Surgery which, among other things, operates (or will when the present construction is finished) 174 hospitals with 131,000 beds. The Department of Medicine and Surgery is allocated two and one half cents of every tax dollar.

There are approximately 20,000,000 veterans which means that one out of every seven and one-half citizens (men, women, and children) is a veteran. Furthermore new veterans are being made constantly as a result of the Korean activity. The Department employs approximately 127,500 full time and part time employees, of whom nearly 24,000 are nurses, den-

tists, and physicians.

The V. A. Hospital is primarily designed to care for service-connected disabilities suffered by veterans. These people have top priority. The hospitals have no out-patient program although the Department does maintain some out-patient clinics for the care of service connected disabilities. No out-patient care is given to non-service connected cases. A veteran with a non-service connected disability is advised upon leaving the V. A. Hospital to continue any needed treatment at his own expense with his local physician. For example, a veteran with a peptic ulcer needs to continue therapy with his own physician. All too often the local physician in an exasperated manner tells the veteran that he doesn't know what the V. A. did for him. It can be found out easily. The V. A. Hospital is more than willing to give a report of its findings and recommendations to the patient's physician — with one provision, the patient must sign a release of information form. All records regarding a patient are considered private and cannot be released without the expressed permission of the veteran. If the patient would sign such a release when he is discharged from the hospital, directing that the information be sent to his own physician, it would be done in a few days, often being in the hands of the family physician before the patient had contacted him. In the case of veterans of the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion, the Congress in 1950 passed a law giving these veterans a presumed service connection for any illness. This for all practical purposes gives these veterans complete medical care, at home or at the V. A. Hospital. This bill was passed over the President's veto and represents a new precedent.

This brings up a very important point, namely, that the Laws, Rules, and Regulations which govern the Veterans Administration are passed and authorized by congress as the duly elected representatives of the people. The V. A. is merely the agency of the people of the United States in carrying out the laws of Congress. These laws vary and are not the same for all veterans. For example, there are specific laws in regard to paraplegics. There are still other laws in regard to the blind. There has as yet been no authorization for the care of a veteran's dependents or for obstetrical care for women veterans. However, some cases of ectopic pregnancy or incomplete abortion have been cared for.

Congress has authorized that a veteran ill with a non-service connected disability can be hospitalized if beds are available and if the veteran in unable to pay for such medical care. No argument has ever arisen in regard to this clause for patients with chronic catastrophic illnesses in the fields of tuberculosis, paraplegia, psychiatry, or neurology. This is probably a silent admission that present day plans do not adequately care for the chronic illness of this kind. Physicians have complained at the loss of revenue when a patient goes to a V.A. Hospital for a hernia repair or a hemorrhoidectomy which they feel, being non-service connected, should go to a private physician. The Veterans Administration is helpless as regards this argument for Congress has given it no power to investigate whether or not a patient is telling the truth when he states he cannot pay.

No patient requires an intermediary such as a service organization to gain entrance into the V. A. Hospital. If he is sick and he presents himself at the admitting office he will be admitted if a bed is available. He needs only his discharge papers showing he is a bona fide veteran.

For patients who are too sick to come, they need only have their family physician call the nearest V. A. Hospital and give the diagnosis along with a statement as to its severity. In an occasional case the local physician, forgetting his own position as a taxpayer, does not accurately report the patient's true condition, perhaps in order to get rid of an unwanted patient. However, most physicians are honest when they call. In these cases the V. A. will pay for transportation, by ambulance in some cases (or send one to their own ambulances), for the veteran from the place of his illness to the nearest V. A. Hospital. This is true for both service connected and non-service connected illnesses if the referring physician states that the patient needs it. Here again the referring physician may forget he is a taxpayer and in order to impress the V. A. with the severity of the patient's illness may recommend ambulance travel when a car would serve as well — and would be more eco-

nomical.

The total cost per patient is less than $14.00 a day. This includes professional salary, laboratory, x-ray, nursing care, rehabilitation, and other items. This is much less than the per day cost for private hospital care which, also, would not include the physician's fee.

Since the reorganization of the Department of Medicine and Surgery in 1945 by Dr. Paul Hawley so that most of the hospitals are connected with medical schools, there has been an enlarged teaching program. All physicians are invited to attend these meetings. In fact, a physician might learn a great deal by visiting a Veterans Hospital such as the one at Hines, Illinois.

The V. A. Hospitals no longer have any waiting lists except in such categories as psychiatry, tuberculosis, and medical neurology. These cases move slowly and the bed turn over is not rapid.

The V. A. Hospitals in Illinois are located at Marion, Dwight, Downey, and Hines. Two new ones are being built in Chicago.

SUSCEPTIBILITY TO ATHEROSCLEROSIS

Atherosclerosis itself in human beings is extremely frequent, and is generally recognized today as the leading cause of death, and one of the greatest contributors to physical and mental incapacity. The exact incidence in our own population is not known. The figures of Wilens, a pathologist at New York University, are revealing. He found that 60 per cent of the Bellevue Hospital population coming to autopsy above the age of 35 revealed moderate or advanced atherosclerosis; between 45 and 54, one-eighth had advanced lesions; at 75 or over the disease was evident in 90 per cent, 50 per cent of the patients examined having advanced lesions. Such figures indicate that in humans, as contrasted with most other animals, the tendency to the disease is so great that almost everyone is affected. The enormously high incidence has given wide credence to the belief that atherosclerosis is the inevitable result of aging. Pathologically, the contrary opinion that it is not inevitable rests only in a study of approximately 10 per cent of the population above the age of 75 in which the disease is inconsiderable or absent. Nevertheless the most single fact about atherosclerosis is that we as members of the human race are extraordinarily susceptible. The question whether this tendency is due to our essential homeostatic mechanisms, or to extraneous factors of diet, mode of life, diseases, and accidents, forms the basis of many of the present investigations and disputes. *Practitioners' Conference. Arteriosclerosis. New York Med. Dec. 5, 1952.*

CORRESPONDENCE



THE WOMAN'S AUXILIARY AND THE STATE MEDICAL SOCIETY

"Aid, ally, assistant, coadjutor, confederate, helper, promoter." All these dictionary synonyms each member of the Woman's Auxiliary should and can be to the Illinois State Medical Society. It is not difficult for groups of doctors' wives organized into County Auxiliaries to find ways to help their county Medical Societies; but sometimes we wives of small-town general practitioners in counties where auxiliary organizations are impracticable feel that we are too alone to be useful. "It aint necessarily so."

You can be a member-at-large. Consider, please, just two of the many possible, and very tangible, ways in which every doctor's wife could help. First, by paying membership dues of $3.00 a year (you may send them to me) you automatically contribute $1.00 to the Benevolence Fund of the Illinois State Medical Society. More and more the Medical Society is depending upon its Auxiliary to build up that fund. Last year we contributed over $6000.00. Last year there were 7552 more members of the Illinois State Medical Society than there were members of the Auxiliary. Simple arithmetic shows that there are about 7500 women who, by the mere act of joining the Auxiliary, could add $7500.00 to the Benevolence Fund. That suggestion is not even altogether altruistic — we never know when we ourselves may need help from that fund.

Having joined the Auxiliary you will receive, as a member-at-large, the same information sent by committee chairmen to each County Auxiliary. A quick reading of the Illinois Auxiliary News and of the letters sent by the state chairmen of program, legislation, public relations, and civil defense can keep you informed and make you a valuable public relations aide to your husband's profession.

You, in small towns, are more important than you realize. You are the only people in your communities who have the information that comes from the State Auxiliary. You are the only ones who are qualified to interpret — not from the soapbox, but through everyday conversations and contacts with local organizations such as P.T.A., Home Bureau, and Woman's Club — the actions and attitudes of the medical profession.

If you really want to work as an Auxiliary member there is much more that you can do. But if your constant cry is "too busy" why not consider the good you can do by just becoming a member-at-large of the Auxiliary? We need you.

(Mrs. G. H.) Jean M. Edwards, Chairman.
Pinckneyville, Illinois

CLINICS FOR CRIPPLED CHILDREN LISTED FOR MARCH

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the March schedule of clinics for physically handicapped children. The Division will count 16 general clinics providing diganostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The March clinics are:

March 3 — Centralia, Recreation Center
March 4 — Rock Island (Cerebral Palsy), Foss Home, 3808—8th Avenue
March 4 — Hindsdale, Hinsdale Sanitarium
March 5 — Chester, St. John's Lutheran School
March 6 — Evanston, St. Francis Hospital
March 10 — East St. Louis, St. Mary's Hospital
March 10 — Peoria, St. Francis Hospital
March 11 — Joliet, Will County T.B. Sanitarium
March 11 — Alton, Alton Memorial Hospital
March 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
March 12 — Springfield, St. John's Hospital
March 13 — Chicago Heights (Rheumatic Fever), St. James Hospital
March 18 — Evergreen Park, Little Company of Mary Hospital
March 18 — Metropolis, Presbyterian Parish House
March 19 — Rockford, St. Anthony's Hospital
March 24 — Peoria, St. Francis Hospital
March 24 — Effingham (Rheumatic Fever), Douglas Township Building
March 25 — Aurora, Copley Memorial Hospital
March 25 — Springfield (Cerebral Palsy), Memorial Hospital
March 26 — Bloomington, St. Joseph's Hospital
March 26 — Macomb, St. Francis Hospital
March 27 — Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

TB SYMPOSIUM FOR GP'S IN SARANAC LAKE NEXT SUMMER

The Second Annual Tuberculosis Symposium for General Practitioners will be held in Saranac Lake, N. Y. from July 13 through 17, 1953. It is approved by the American Academy of General Practice for 26 hours of formal credit for its members.

The Symposium is sponsored by the Saranac Lake Medical Society and the Adirondack Counties Chapter of the New York State Academy of General Practice. The registration fee is $40 for A. A. G. P. members and $50 for nonmembers. Registration is limited to 100 doctors.

Many physicians who attended last year's symposium brought their families to Saranac Lake. So that families might have use of the car to enjoy the many recreational facilities of the Adirondack Mountains, free bus transportation was provided for physicians from Saranac Lake to the various meeting places. This practice will be followed again this year.

Many of the sessions are informal panel discussions with ample opportunities for questions from the audience.

The Symposium will be held in various sanatoria and laboratories in the Saranac Lake area. Morning sessions will be from 8:30 to 12:30 and afternoon sessions from 2:00 to 3:30 (Monday, Wednesday, and Thursday). There will be

elective sessions on Tuesday and Friday afternoons. Physicians desiring to make patient rounds will have that opportunity each afternoon at 4:00. On Monday, July 13th there will be a dinner for physicians attending the course, their families and the faculty.

The speakers and panel members at the Tuberculosis Symposium will include physicians, surgeons and scientists from Saranac Lake and surrounding areas.

Complete information concerning this program can be obtained by writing: Richard P. Bellaire, M.D., Tuberculosis Symposium for General Practitioners, P. O. Box 707, Saranac Lake, New York.

PREPARE MANUAL FOR ARTHRITIS CLINICS

A Manual for Arthritis Clinics, said to be the first of its kind, is just off the press from the Arthritis and Rheumatism Foundation, according to an announcement by the national medical director, Dr. Gideon K. deForest, at Foundation headquarters in New York City. The Manual was published jointly with the National Institute of Arthritis and Metabolic Diseases. The 64-page book not only contains practical information on the administration of a clinic for the rheumatic diseases but also diagnostic criteria covering the 30 or more arthritides, criteria for grading the effectiveness of therapy, information on selecting and training clinic staff, and the use of social workers and volunteers. The material is considered definitive as it was prepared by a special committee of the New York Rheumatism Association in cooperation with the New York Chapter of the Foundation.

"The limited number of arthritis clinics — only about 250 in the whole country for an incidence of approximately 7,500,000 cases — is a well recognized fact," said Dr. deForest, "and more and more hospitals are moving to increase their facilities in this regard. This book is aimed to supply needed information on setting up an efficient clinic."

Priced at 50 cents, copies may be obtained by writing to any of the 32 Chapters of the Foundation or to national headquarters, 23 West 45th Street, New York 36, N. Y.

PHYSICIANS WANTED IN STATE HOSPITALS

A severe shortage of Physicians and Tuberculosis Control Physicians still exists in several Illinois state hospitals.

Oral tests for Physician I, Tuberculosis Control Physician I, and Psychiatrist I will be held as often as a sufficient number of persons apply.

Higher starting salaries for the positions were announced recently by the Welfare Department because of the shortage.

Physicians who satisfactorily complete three years of service with the Department of Public Welfare are eligible for an educational leave of absence with full pay to conduct research or study approved by the Department.

Additional information and application forms may be obtained from local offices of the State Employment Service or from the Civil Service Commission, Armory building, Springfield.

FELLOWSHIP IN INTERNATIONAL COLLEGE OF SURGEONS

Qualifying examinations for Fellowship in the United States Section of the International College of Surgeons will be held on the following dates in 1953: February 2 and 3, May 4 and 5, August 10 and 11, and November 2 and 3. The examinations will be given at the Cook County Graduate School of Medicine, and the Cook County Hospital. Applicants are requested to address communications as follows:

Harry A. Oberhelman, M.D., Secretary
Qualification and Examination Council
1516 Lake Shore Drive
Chicago 10, Illinois

NEW EDITORIAL CONSULTANT FOR WILLIAMS & WILKINS CO.

It is announced by The William & Wilkins Company, medical publishers of Baltimore, Maryland, that effective with January 1953 Dr. Henry J. L. Marriott will become consultant to their editorial department.

Dr. Marriott is Assistant Professor of Medicine at the University of Maryland School of Medicine and is the author of a recent popular book, published by The Williams & Wilkins Company, entitled, "Medical Milestones".

OBSTETRICIANS ELECT OFFICERS, LAUNCH NEW JOURNAL

More than 1100 Fellows and non-members attended the First Annual Clinical Session of the American Academy of Obstetrics & Gynecology in Chicago December 15-17, 1952.

Robert A. Kimbrough, Jr., Philadelphia, was installed as the third president of the Academy. Bayard Carter, Durham, No. Car., was chosen president-elect to take office a year from now.

Other new officers elected include: C. Paul Hodgkinson, Detroit, secretary; Charles D. Kimball, Seattle, assistant secretary; Joe Vincent Meigs, Boston, second vice president. Re-elected were Howard Stearns, Portland, Ore., first vice president and Herbert E. Schmitz, Chicago, treasurer.

The Acadamy's Second Clinical Session will be held in the Netherland Plaza Hotel, Cincinnati, December 14-16, 1953. Chairman of the Program Committee is Andrew J. Marchetti, Washington, D. C. Local Arrangements Chairman is Arthur G. King, Cincinnati.

Texts of formal papers presented at the First Clinical Session will be printed in the Academy's new journal, "Obstetrics and Gynecology", beginning with the first issue in January 1953.

Published monthly, the journal will be edited by Ralph R. Reis, Chicago. It will contain some 120 pages of scientific material in each issue, as well as other items of interest to physicians practicing obstetrics and gynecology.

The following educational scientific exhibits were given awards for excellence at the First Clinical Session:

First place — "Significance of Circulatory Phenomena in Abruptio Placentae", Charles L. Schneider, M.D., Ruby E. Engstrom, M.D., and Robert G. Braden, M.D., of Wayne University, Detroit, and Wayne County General Hospital, Eloise, Mich.

Second place — "Pregnancy in the Bicornuate Uterus", Frederick H. Falls, M.D., and Miss Charlotte S. Holt, of the University of Illinois College of Medicine and Illinois State Department of Public Health, Chicago.

Third place — "Pathology of Ovarian Tumors", Edward G. Winkler, M.D., and Gordon J. Hippert, M.D., of University of Buffalo School of Medicine, Edward J. Meyer Memorial Hospital and Sisters of Charity Hospital, Buffalo, N. Y.

Honorable Mention — "A Simple Test for Early Pregnancy, Ovulation, and Estrogen Activity by the Use of the Cervical Mucus Secretion", Maxwell Roland, M.D., of New York Post-Graduate Medical School, New York University, Bellevue Medical Center and Queens General Hospital, New York, N. Y.

AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1953 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1953 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1953. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

PRACTICAL NURSE ASSOCIATION OF ILLINOIS

The Annual Convention for The Practical Nurse Association of Illinois, is scheduled for March 5, 6, and 7, 1953, at the Hotel Orlando, Decatur, Illinois.

Sincerely Yours
Ellen E. Marsh, L.P.N.
Chr. State Program Comm.
235 South Webster
Decatur, Illinois

ORIGINAL ARTICLES



Rabies — The Doctor's Dilemma

Howard J. Shaughnessy, Ph.D.,
Deputy Director, Division of Laboratories, Illinois Department of Public Health

Unfortunately, because Illinois falls in the area in which the incidence of animal rabies is very high, every animal bite must be considered as a potential exposure to rabies. About fifteen thousand persons are reported to be bitten by animals each year in Illinois. Thus, the potential number of exposures to rabies is high.

The fact that all biting animals are not rabid creates one horn of the doctor's dilemma. The other horn arises from the fact that antirabic vaccine is not innocuous and, therefore, should not be administered to anyone probably not exposed to actual risk of infection. Since, it is not always possible to determine with certainty the true risk of exposure, in practice the dilemma resolves itself into the necessity of weighing the relative risks of contracting rabies versus development of post-rabic vaccine paralysis.

There is now general agreement that the danger of contracting rabies is confined to the following groups of persons: 1. Those exposed to clinically rabid animals; 2. Those exposed to animals proved to be rabid by laboratory examination; 3. Those exposed to animals which cannot be identified; 4. Those children who have probably been exposed to a rabid animal but who are too young to give reliable testimony concerning the exposure.

Exposure may be defined as the condition which exists when wet saliva comes into contact with fresh, open wounds or abrasions. Deposition of saliva on unbroken skin or on old scab-covered wounds does not constitute real exposure to rabies.

While the condition of the biting animal is being determined by observation and/or laboratory examination, the patient's wounds should be freed from rabies virus as quickly and thoroughly as possible. The expert committee on rabies of the W H O has recommended that irrigation with 20% soap solution be used in place of cauterization with fuming nitric acid. More recent studies indicate that swabbing wounds artificially contaminated with rabies

virus with 1% refined benzalkonium chloride (zephiran) is even more effective than irrigation with soap solution.

Because of the greater risk of infection following bites on the head or severe bites elsewhere, it may be necessary in some cases to begin anti-rabic vaccination of the patient before the condition of the biting animal is known. Johnson states that average incubation periods following bites on the areas indicated are as follows: head 30 days, arm 50 days, leg 44 days. The fatality rate also varies with the location and type of wound. The following table (Table 1) from Babes gives the fatality rates in untreated cases. Treatment may be discontinued after a week if the animal has shown no signs of rabies in the interim. The only reason for doing so is the danger of post-vaccinal reactions.

TABLE 1

Fatality Rates in Untreated Rabies
(Adapted from Babes[4])

Type of Exposure to Rabid Dog	Fatality Rate %
Multiple and deep wounds of face	50-60
Multiple and deep wounds on other uncovered parts	30
Superficial wounds on uncovered parts	10
Deep wounds on covered parts	3
Contact of recent wounds with infected saliva	0.1
Contact of wounds more than 24 hours old	0

It has usually been stated in the past that post-vaccinal reactions of the neuro-paralytic type occurred in about one patient in each two to three thousand persons vaccinated. The incidence is now believed to be higher. Horack reported a ratio of 1:1200 (10% fatal) in twenty-four thousand treated persons. Pait and Pearson reported an incidence of 1:600 (1 fatal) in 5,500 treated. Our recent analysis of about 25,000 cases showed an incidence of 1:1700 (2 fatal). Probably all of these figures are subject to errors. Some instances of even severe reactions go unreported. In other cases the reported actions have been slight and may have been unrelated to the administration of the vaccine.

All observers are agreed that the risk of neuro-paralytic reactions is much greater in those who have had a previous course of inoculations with vaccine. Therefore, reimmunization should not be given in borderline exposures and, if given at all, should be limited to a short booster course of 5 to 7 injections. Authorities also agree that vaccination should be discontinued as soon as early signs or symptoms of impending serious reactions appear such as headache, fever, nausea, weakness, numbness or tingling sensations in the extremities.

Since the mechanism by which these reactions are produced is not known, although suspected to be on the basis of allergy to some substance in the vaccine, there is no way of treating the vaccine to render it incapable of producing neuro-paralytic reactions.

It has been suggested by some that, since anti-rabic vaccine appears to cause these untoward reactions, its use be discontinued. It has even been stated that anti-rabic vaccine causes more deaths than rabies. The author cannot agree with this thesis because he feels that there is good evidence in favor of rabies vaccine. It is possible to develop a high degree of protection against rabies in animals with modern vaccines. In persons practically all vaccine failures can be explained on the basis of poor quality vaccines such as were used in the past, failure to administer the vaccine soon enough after exposure, or the occasional instance in which the incubation period is so short that there has been no time for antibodies to develop following vaccination. Indeed, one of the strongest pieces of evidence in favor of vaccination is the fact that prior to vaccination 80% of cases had incubation periods of over 30 days whereas in the vaccinated most cases occur after a short incubation. As a matter of fact, in Illinois rabies very rarely occurs in a vaccinated individual. Most cases occur in those who for some reason have failed to get vaccine.

The only way that the value of anti-rabic vaccine could be shown without doubt is by an alternate case series. It is unfortunate that this was not done in the early days of vaccination. The nearest we can come to such a series now is Cornwall's earlier data in which he compared the fatality rates in persons bitten by the same animals, some of which accepted or rejected treatment, respectively. The rates were 2.9%

in the 812 treated persons and 6.2% in the 1,362 untreated. More recent figures for 1949-1950 from the same institution in which Cornwall gathered his figures show that 9.5% of 84 completely treated patients died whereas 44.2% of 43 untreated persons bitten by the same animals succumbed. One would assume that these figures would be weighted in favor of the untreated group, because it would appear logical that the most severely bitten patients would be more likely to seek treatment and the less severely exposed would not. It must be emphasized that these figures represent the experience with vaccines which probably were inferior to those in general use in this country.

If we can assume that vaccination is effective against the usual exposure, then we apparently need a better weapon against the severe type of exposure exemplified by the face bite or severe bites elsewhere. It is possible that hyperimmune serum may be useful in these instances. This anti-serum produces protection for a limited time so when it is employed a subsequent course of rabies vaccine must be given. It is now believed that five to seven injections of vaccine may be enough if antiserum has been previously given. It is hoped, but not proved, that the incidence of neuroparalytic reactions following this shorter course of injections will be materially lowered.

Meanwhile, the physician must continue giving vaccine when it is necessary. The only way he can escape the horns of the dilemma is to weigh the relative risks in each case and administer or withhold vaccine in accordance with his best judgment. This makes it imperative to intensify the efforts to improve methods of preventing rabies in man. We must strive especially to bring the disease under control in animals to such an extent that need of vaccination in man may be lessened or even eliminated — as it has been in some other areas.

Hazards and Pitfalls of Anticoagulant Therapy

Richard M. Shick, M.D.
Division of Medicine, Mayo Clinic,
Rochester, Minnesota

Coagulation of blood within an intact blood vessel is distinctly abnormal. Anticoagulants are used for the purpose of maintaining the blood in a fluid state, regardless of the abnormalities which favor intravascular coagulation. They are used in clinical practice to prevent thrombo-embolism or to prevent extension of thrombosis which has already occurred.

An adequate method for predicting the occurrence or progression of thrombo-embolism does not exist, and therefore many patients receive anticoagulants who do not actually need them. The clinician who uses anticoagulants must treat many patients to save the lives of a few, and to spare a few more patients the consequences of progressive thrombosis. This situation will persist until some method is developed by means of which the occurrence of thrombosis can be predicted or until it is possible to predict with accuracy whether or not a minor episode of thrombosis will progress or cause embolism. Until these goals have been achieved, the physician will need to treat prophylactically those patients who are likely to have or who already have thrombosis. The only alternatives are to ignore the advantages of anticoagulant therapy, to use some other method of treatment, such as ligation of veins, or to accept the consequences of thrombosis. A major challenge to the medical

Read at the meeting of the Illinois State Medical Society, Chicago, Illinois, May 13 to 15, 1952.

profession today is the development of a means of determining the likelihood of thrombo-embolism before it actually occurs.

Heparin.—Heparin is expensive, must be given parenterally and requires injections by medical personnel. It can be administered in three ways: (1) by continuous intravenous injection, (2) by intermittent intravenous injection and (3) by deep subcutaneous or intramuscular injection in either an aqueous solution or a slowly absorbed medium.

The continuous intravenous injection of heparin, although theoretically ideal from the standpoint of continuous anticoagulant effect, poses certain problems which make this mode of administration inconvenient and at times impractical. It requires constant and careful supervision of the apparatus and frequent tests of the Lee-White coagulation time. The method is not practical for use for more than ten days.

The intermittent injection of heparin ignores individual differences in tolerance of heparin and also the fact that the method exerts little or no demonstrable effect on the coagulation time for periods longer than two to three hours after each injection. However, in clinical practice this method seems to be effective and does not require tests of the coagulation time.

The use of heparin in a slowly absorbed medium by deep subcutaneous or intramuscular injection has gained in favor, but opinion is divided as to its efficacy and safety. The earlier preparations frequently produced pain at the site of injection. More recent preparations appear to have minimized these disadvantages. Standardization of dosage is difficult because of differences in rate or absorption of the drug, as well as differences in tolerance of heparin. The method requires repeated tests of the coagulation time.

Heparin produces a more profound effect on the coagulation mechanism than does dicumarol. Even in the therapeutic range of anticoagulant effect, there appears to be a greater tendency toward bleeding when heparin is used than when dicumarol is used. If the bleeding is external and detected, the effect of heparin can be stopped quickly, but if it is internal, a dangerous situation may develop before it is recognized.

The effect of heparin can be neutralized by the intravenous injection of 50 mg. of protamine sulfate (salmine). If heparin in a slowly absorbed medium has been used, it may be necessary to apply an ice bag to the site of injection and to repeat the dose of protamine sulfate. If major hemorrhage occurs, blood should be given to replace loss of blood.

Coumarin Compounds.—Dicumarol (bishydroxycoumarin) has the advantage of being cheap and easily administered. Disadvantages are delay in adequate effect for one or more days after administration and delay of subsidence of effect for several days after administration has been discontinued. Another disadvantage is the great difference in response among different patients to fixed doses.

In treatment with dicumarol, the aim is to produce and maintain a moderate but not excessive deficiency of prothrombin. The dose must be individualized for each patient on the basis of his or her reaction to certain fixed amounts of the drug which are given initially. The dose must be varied as necessary during the entire period of administration, and it depends on the response of the particular patient being treated.

We use the Magath modification of the Quick test of prothrombin time for prothrombin activity in the blood plasma. The type of thromboplastin used in performing the test is unimportant, provided the prothrombin time reported by the laboratory can be converted into percentage of prothrombin activity. It is considered safe to maintain the prothrombin time within a range of 2 to 2½ times the value for normal plasma, provided the value for normal plasma does not exceed 20 seconds. The values for prothrombin activity with this method would be about 15 to 20 per cent of normal with the method used in our laboratory. However, a therapeutic range of 10 to 30 per cent of normal prothrombin activity usually is satisfactory and relatively safe.

The use of dicumarol is entirely inadvisable unless the laboratory has on hand equipment and personnel to render wholly reliable reports. This constitutes the sine qua non of treatment with dicumarol. To administer dicumarol without adequate and reliable laboratory control is to court disaster from hemorrhage, or to treat a patient inadequately. The same applies to the use of the newer coumarin derivatives, tromexan (ethyl biscoumacetate), and cumopyrin (cyclocumarol).

Tromexan is approximately one fifth as potent as dicumarol, milligram for milligram. It acts

somewhat more rapidly and its effect disappears more rapidly after administration is discontinued. These potential advantages are somewhat offset by greater difficulty in maintaining the prothrombin time within the therapeutic range. Tromexan can be given with dicumarol at the beginning of anticoagulant therapy in order to produce a deficiency of prothrombin more rapidly.

Cumopyrin is two to three times as potent as dicumarol, milligram for milligram. It acts as rapidly as, or slightly more so, than dicumarol and its effect disappears somewhat more slowly after administration is discontinued. To date clinical experience is inadequate for satisfactory appraisal of whether this drug has any definite superiority over dicumarol, but further trial and study are in progress.

An excessive effect of dicumarol may be neutralized by menadione sodium bisulfite (vitamin K) administered intravenously in doses of 36 to 72 mg., depending on the apparent urgency of the situation. Vitamin K_1 or vitamin K_1 oxide in doses of 200 to 500 mg., given either orally or intravenously, is a more effective and rapidly acting antagonist and should be used in cases in which significant bleeding is encountered or in which there is other reason for stopping the action of dicumarol as rapidly as possible. Significant loss of blood should be replaced by transfusion.

Contraindications to the Use of Anticoagulants.—Contraindications to the use of any anticoagulant may be summarized as follows: (1) subacute bacterial endocarditis, because of the danger of cerebral hemorrhage; (2) recent operation on the brain or spinal cord, because of severe damage which might follow even minor hemorrhage in these regions, and (3) purpura and blood dyscrasias associated with a bleeding tendency, because of increased tendency to bleed.

Contraindications to the use of dicumarol but not to heparin include: (1) renal failure, (2) hepatic insufficiency, and (3) lack of trained laboratory personnel and of adequate facilities for determining values for prothrombin time. The risk of performing surgical operations or paravertebral sympathetic blocks, or producing spinal anesthesia while anticoagulants are in effect, cannot be too strongly emphasized.

Caution should be employed in the use of anticoagulants or the drugs should be withheld when there are ulcerating lesions of viscera or skin, because of the danger of hemorrhage. There is some increased danger from hemorrhage when anticoagulants are given to patients who are being treated with Wangensteen or Miller-Abbott tubes or who have indwelling catheters or other tubes in body orifices or wounds. Dietary or nutritional deficiencies also call for increased caution in the use of dicumarol. In a considerable number of instances the clinician will need to decide about the administration of anticoagulants on the basis of potential harm and potential good; the decision may be difficult.

Danger of Hemorrhage.—Whenever anticoagulants are used in therapeutic doses there is some danger of bleeding. We have not used heparin sufficiently long for a sufficiently large number of patients to permit us to judge the incidence of bleeding. We have observed bleeding during the use of heparin in a few instances shortly after surgical operations, and in one instance after myocardial infarction.

Much of the serious bleeding which has been encountered during the administration of dicumarol has been due to gross overdosage of the drug arising from error or disregard for the importance of frequent tests of the prothrombin time; however, even if adequate supervised therapy is employed, there is a small risk of serious local bleeding. One investigator[1] recently reviewed the instances of serious and fatal hemorrhage during the administration of dicumarol which had occurred in a number of institutions since the drug had been introduced. He found that the mortality rate attributable to hemorrhage was 0.18 per cent among 15,500 patients. A number of fatalities occurred in the early years after dicumarol was introduced; similar results probably would not occur now that contraindications to the use of the drug are known more generally and the prothrombin time is determined with greater accuracy.

When an anticoagulant is used, the risk of bleeding among surgical patients, and particularly bleeding from operative wounds, is higher in the immediate postoperative period. However, this risk has been minimized by withholding anticoagulant therapy until the third postoperative day. In an earlier series of almost 2,000 postoperative patients given dicumarol, my associates[2] encountered minor bleeding in 3.4 per cent of cases and major bleeding in 1.8 per cent

of cases. There is, of course, a great difference between major bleeding and fatal hemorrhage. Although marked bleeding occurred about forty times during the course of treatment, death from hemorrhage occurred but twice. Careful study of these two fatalities indicated that fatal hemorrhage could not be definitely attributed to the effect of dicumarol. Among the last 2,000 postoperative patients treated with dicumarol, my associates and I have observed no instances of fatal hemorrhage. Another group of investigators[3] have reported that 3,304 patients were given dicumarol after major abdominal and pelvic surgery without any deaths due to hemorrhage and with only three instances of bleeding sufficient to require the transfusion of blood.

A study of the incidence of bleeding in 288 "medical" patients treated with dicumarol[2] revealed that minor bleeding occurred twice (0.7 per cent) and major bleeding three times (1.0 per cent). In the latter group were two instances of gastrointestinal bleeding, and one instance of severe subcutaneous bleeding. There were no deaths due to hemorrhage.

SUMMARY

Extensive experience has indicated that the anticoagulants, heparin and dicumarol, are useful in medical practice. However, the use of either alone or the two together, particularly over long periods, is far from satisfactory. Heparin is expensive, must be given parenterally, and requires injection by medical personnel. Treatment with dicumarol requires repeated tests of the prothrombin time.

The statements in the medical literature that dicumarol is a "dangerous" drug are unjustified if the drug is properly given. However, unless personnel of the available laboratory are well versed in the pitfalls of determinations of prothrombin time, heparin rather than dicumarol is the safer drug. The clinician is adjured to acquaint himself with the contraindications to the use of heparin and dicumarol as well as the laboratory methods of their control, or else to refrain from using anticoagulants altogether.

CONCLUSIONS

It is apparent that treatment with anticoagulants will not be wholly satisfactory until one is available which is cheap, which can be given orally and which, in identical amounts, will always have identical effects on the coagulation mechanism. Until this desideratum has been achieved, clinicians will need to be satisfied with less than an ideal situation.

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THE PHYSICIANS BULLETIN

In step with the busy schedule of today's doctor, Eli Lilly and Company has conceived an entirely new format for its house publication *The Physician's Bulletin*. Starting in January, 1953, the new "PB" is designed to give brief, concise information in a handy form to the 150,000 doctors who receive it.

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The Physician's Bulletin is edited by S. O. Waife, M.D., with the assistance of other physicians who serve full-time on the Lilly staff.

Aging

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In discussing "Aging", we shall consider the aging process particularly as applied to the human, then diseases of later years, and finally suggestions for achieving better health in later years.

1. Aging Process in Man. Aging may be defined as a biological change which occurs with time and involves alterations in the structure and function of the various body parts, commonly in the direction of decreased capacity and adaptability. Although aging as here defined is fundamentally a biological phenomenon, it obviously has important social and economic implications. Aging is the last of the sub-divisions of the life process, the others being growth, development, and maturation. There are a few biologists who maintain that if the human and other living things were not subjected to various adverse influences in their environment, including disease, immortality on earth would be obtainable. However, the preponderance of evidence supports the concept that aging occurs as a normal life process even in the absence of adverse environmental influences. Indeed, the evidence is good that aging begins with conception and continues through life at a gradually accelerated pace. Thus the arteries of a ten year old child are less elastic than those of a five year old.

In addition to defining aging, we should also define the closely related terms, gerontology and geriatrics. Gerontology is the biological science which deals with the physiological and pathological changes which occur with aging. In its broadest sense, gerontology very properly includes the sociologic and economic aspects of aging. Geriatrics is that branch of medicine which is concerned with the care of older and aged people. Geriatrics, therefore, is a subdivision of gerontology.

From time to time, biologists and physicians discuss the question of the normal human life span. Again, there are a few who contend that barring disease processes and other unfavorable environmental influences, the normal life span for man could be 150, 250, or even more years. Certainly only a small percentage of humans presently dies of uncomplicated old age. Nevertheless, present biological evidence favors the probability that the life span for the human will rarely exceed 100 years, or certainly 125 years, no matter what the future portends for advances in biological and medical knowledge. The few recorded instances of human longevity equalling 150 years are most probably the result of inaccurate vital statistics. Thus the famous English physiologist and physician of the seventeenth century, Dr. William Harvey, who is credited with the discovery of the circulation of the blood expressed doubt in his postmortem report of the reputed age of the oft-cited Tom Parr who was supposed to have lived 152 years. Each species has a more or less characteristic life span which varies from a few minutes in the case of certain insects to 7000 years for certain trees.

As all of you know, our average life span in the United States has steadily increased during the present century, due principally to improved public health and sanitary facilities, decreased infant mortality, and decreased mortality in youth and early maturity from infectious diseases chiefly as a consequence of the sulfa drugs and the antibiotics such as penicillin. The life expectancy for girl babies born today is 71 years and that for boy babies 68 years. Presently our population includes 11,000,000 people over 65 years of age and the predicted numer for 1960 is 14,000,000. On the other hand, there has been no increase in the life expectancy of those who reach the age of 40 in the United States or elsewhere. This is due to the fact that biological and medical knowledge of the diseases characteristic of later years has advanced only moderately

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to date and that treatment of the two principal causes of death in the United States, viz., heart disease and cancer, is still only relatively satisfactory.

While the aging process extends throughout life, it becomes sufficiently advanced after 40-50 years to be apparent to the casual observer. During the latter half of middle age, i.e., from 50-65 years, the changes further accumulate to warrant the designation of old age for those over 65 years. However, strong emphasis must be placed on the fact that biological age and chronological age are not necessarily the same. Some men and women are younger at 65 or 70 than are others at 45 or 50. Moreover, the various organs and body parts do not undergo aging at the same rate. Undue aging of the brain will have more serious consequences for the individual than undue aging of other body parts.

With advancing years, the skin becomes more wrinkled, thinner and less elastic and pigmented areas develop. The hair of the head becomes grey, frequently thin, and sometimes largely absent, whereas curiously enough, the hair of the eyebrows, nostrils, and ears increases in length. The features, particularly the nose, become somewhat heavier, probably as the result of changes in the secretion of the pituitary gland at the base of the brain. The skeletal and other supporting tissues show changes which include a decrease in the calcium or lime content of the bones, slight overgrowth to produce roughened surfaces and edges of some of the bones, atrophic changes in the cartilage or grisel covering the bones, particularly at the joints, and decrease in size, strength and elasticity of the tendons and ligaments which join the bones of the skeleton together. The nervous system and the sense organs associated with it show a decrease in function. Thus the time to react to our environment, such as the change of a traffic light to red when driving an automobile, is increased with advancing years. The number of brain cells decreases and some of the remaining cells develop pigment, although this decrease does not cause significant impairment in the higher intellectual processes of most people over 50 and of many over 65. Furthermore, the knowledge, judgment, and experience resulting from having lived 50 years will usually more than compensate for brain cells lost, so that the important directive work of the world is, from a biological point of view, best placed in the hands of men 45 to 60 years of age. Obviously there are exceptions to this. Skeletal muscle movements which are, of course, directed by the nervous system, are less well coordinated, less rapid, and less accurate than in earlier years. The skeletal muscles decrease in size and strength with advancing years. In part for these reasons but also because of the aging of the heart, blood-vessel, and breathing functions, participants in many sports are considered to be old when they reach the thirties. On the other hand, these aging changes in nervous tissue and muscle do not prevent many artists and skilled craftsmen from successfully pursuing their work into old age. The senses also show certain decreases with advancing years. Best known perhaps is the gradual loss of elasticity in the lens of the eye which goes on throughout childhood and maturity and necessitates the use of reading glasses or bifocals at 45-50. There is also a gradual decrease in hearing for tones of higher pitch and a decrease in the acuity of smell and taste with increasing years.

It is frequently said that a man is as old as his arteries. This statement is based on the fact that at the present time, the Captain of the Men of Death in our Western World, is arteriosclerosis or hardening of the arteries. However, it should be emphasized that the kind of artery hardening which produces death is not a part of the normal aging process but is really a disease which will be discussed in the next section of this lecture. Nevertheless, the arteries do become less elastic with passing years and the heart muscle carries on with a decreasing reserve. Moreover, the lungs function less adequately in bringing oxygen to the blood in the lungs due to a decrease in the elastic tissue in the lungs and other factors. The respiratory tract reserve, i.e., ability to hyperventilate the lungs and supply greater amounts of oxygen under conditions of increased demand, such as exercise, is also gradually reduced with age.

The gastrointestinal tract likewise shows evidences of aging. During the first half of life, permanent teeth are lost chiefly as a result of dental caries, the cause, prevention, and treatment of which are still insufficiently known. In later years, teeth are lost through caries but more through periodontal disease, i.e., inflammatory and other changes about the tooth. It is a sad commentary that at the age of 50, 30

per cent of American people need complete artificial dentures. The stomach and bowel, as well as the liver and the pancreas, show gradual decreases in functions and size with the years. Thus the lining of the stomach becomes thinner and secretes less hydrochloric acid, so that by 50, one-quarter of humans have no acid in their gastric juice. This is not particularly serious since other digestive enzymes in the bowel will cover for the stomach. The smooth muscle of the stomach and bowel shows a gradual but modest decrease in size and motor activity, yet the previous bowel rhythm is frequently maintained in later years. Barring frank disease of the gastrointestinal tract, this system is usually capable of carrying on for many years after some other system of the body, usually the heart and arteries has become sufficiently crippled in function to produce death.

After 50, the size of the skeletal muscles and other organs, such as the liver, kidney, pancreas, and glands of internal secretion, decreases somewhat and the amount of fatty tissue, which is chemically much less active, increases. Hence the basal metabolic rate which measures the biochemical activity of the body is somewhat decreased with advancing years. While nutritional deficiencies involving vitamins, minerals, proteins, and/or calories occur occasionally after 50, as they do prior to this age in the United States, the most common nutritional abnormality after 50 is over-nutrition or obesity. And this is so despite the fact that well-publicized statistics show that those who are overweight have their life expectancy significantly shortened. The kidneys show a gradual but slight decrease in their various functions, chief of which, of course, is ridding the body of the waste products of its activity. The urinary bladder ordinarily continues to empty satisfactorily, except when an enlarged prostate gland may interfere with this function in otherwise normal older men.

The endocrine glands or glands of internal secretion have long been associated in the lay mind with aging and more particularly with the possibility of reversing the process. In general, the glands of internal secretion which produce chemical messengers to influence and regulate the activities of many organs and tissues of the body, show a gradual and slight decrease in function with passing years. Among these are the thyroid in the neck, the pituitary at the base of the brain, and the adrenal glands above the kidney. Rarely there occurs a condition of premature or tremendously accelerated aging as the result of which a five year old child may have the appearance of a 70 year old. In this disease, known as progeria, the pituitary gland is markedly deficient in function. At 45-50 usually, the ovaries cease producing eggs and hence menstruation which is the outward expression of the process intended to receive the fertilized egg, ceases. There is also a decrease in the sex hormones produced by the ovary. This is a normal part of the aging process and the rapid aging of the ovaries at this time is not paralleled in other organs of the body. Certainly this change should be considered as normal or physiological and such an understanding by some women may be sufficient to enable the avoidance of hormone or other therapy during the menopause. In the male, testicular function undergoes a more gradual decrease. Despite many attempts to rejuvenate men and women through sex hormone therapy and various surgical operations, there is incontrovertible evidence that the normal aging of various organs and tissues has little relation to the gonads and sex functions. Accordingly, it is scarcely surprising that these procedures have been quite unsuccessful in slowing or reversing the aging process.

II. Diseases of Later Years. Obviously people over 50 are subject to the various diseases which are found in those who are younger. Thus whooping cough may occur after 50. When infectious diseases such as pneumonia or tuberculosis occur in older individuals, as would be expected, the recovery period is somewhat longer. Recovery from the effects of accidents, which it should be remembered now constitute the third cause of death in the United States, is also slower. Moreover, in later years, one or more of a group of diseases may occur which are uncommonly seen in earlier years. These diseases are likely to be gradual in development and chronic and progressive in course, with considerable individual variation. Sometimes more than one of these conditions may be present in the same person. They are frequently spoken of as degenerative diseases, although it should be emphasized again that they are definitely not a part of the normal aging process. The chief members of this group are heart and kidney disease, cancer, and arthritis or rheumatism.

The principal causes of heart and kidney disease in later years are high blood pressure or hypertension and hardening of the arteries or arteriosclerosis. Together these diseases now account for more than one-half of all deaths in the United States. Ninety-five per cent of all patients with high blood pressure have their increased blood pressure as the result of incompletely or poorly understood cause or causes. Five per cent have their hypertension due to a known cause such as infection of the kidney or tumor of the adrenal gland. It is important to recognize these hypertensions of known cause since in some patients the cause can be eradicated and the high blood pressure completely cured. Our treatment of the common form of high blood pressure, on the other hand, is less satisfactory, although some patients are cured and others considerably improved by present methods of treatment. While we are not sure of the exact cause of the common form of high blood pressure, we have evidence that the nervous system, the endocrine glands, particularly the pituitary gland and the adrenal glands, and the kidney are involved in the causation. In some way these organs cause constriction or narrowing of the smallest or microscopic arteries of the body. As a result, the heart must pump more forcibly to move the blood through the narrowed vessels, thereby increasing the pressure of the blood or blood pressure in the larger arteries. Obviously the work of the heart is increased by hypertension. Also hypertension accelerates the progress of hardening of the arteries which is not infrequently present in patients with high blood pressure, including sclerosis and narrowing of the coronary or heart arteries. As a consequence, the heart may function inadequately. The brain arteries are thin-walled and sometimes brain hemorrhage or stroke occurs. Less frequently there is inadequacy of kidney function. However, it should be remembered that while these complications of high blood pressure do occur, there are patients with hypertension whose condition shows little change from year to year and who live out their normal life span and die of old age. High blood pressure has been produced experimentally in dogs by partial constriction of the renal arteries or arteries supplying the kidneys. This hypertension in practically all respects so far studied resembles the common form of human hypertension which suggests, but does not prove, that the kidney may be involved in the causation of hypertension in man. Our laboratory has recently developed a successful treatment for experimental hypertension in the dog but unfortunately several more years of work are necessary before it will be ready for possible trial in man. Nevertheless a number of important advances in the treatment of high blood pressure have been made in recent years. New drugs are presently being tested in treatment. A low salt diet produces what in effect is a cure in about 10 per cent of patients treated. And likewise, a nerve cutting operation effects what is tantamount to a cure in about 10 per cent of patients, and appears to improve the general condition and prolong the life span of others.

Hardening of the arteries or arteriosclerosis is a condition in which there is thickening of the wall of the arteries with accumulation of fatty substances and calcium, often with narrowing of the lumen of the vessel. Especially involved are the aorta which is the great artery coming off the heart and certain of its important branches; viz., the coronary arteries which supply the heart muscle with blood, the cerebral or brain arteries, and the leg arteries. The narrowing of the arterial lumen reduces the blood-supply to the given organ or body part and thereby produces interference with the normal activity of that organ. Thus there may be heart pain if the coronaries are narrowed, altered thinking if the cerebral arteries are too narrowed, and leg pains particularly on walking from narrowed leg arteries. The lining of the narrowed arteries is frequently roughened and a blood clot may form and still further reduce the blood supply to the organ or part. This is what happens in coronary thrombosis or so-called heart attack. The chief reason why the life expectancy of American men is three years less than American women is the greater number of deaths from heart attacks in the former. The basic cause of hardening of the arteries is not yet known, although recent work shows that certain changes in the way the body handles fatty substances are present. Experimental hardening of the arteries has been produced in various laboratory animals and the study of the experimental disease is yielding important information. Most important of all we have learned that hardening of the arteries is a reversible process which means that not

only will we some day be able to prevent the disease and to stop its progress in man but also to bring about its disappearance or cure. Recent work shows that certain drugs are of value in the treatment of human arteriosclerosis. This is likewise true for a nerve cutting operation in selected patients. Presently there are important studies being conducted on treatment with certain food substances which are fat antagonists and on treatment with a low fat diet.

The Illinois Heart Association, the Chicago Heart Association and the American Heart Association are conducting an educational campaign to inform the public concerning diseases of the heart and bloodvessels. An important part of the educational effort of the Chicago Heart Association is an excellent exhibit on the heart which is intended to enable each of us to "live with his heart longer through understanding it better". This exhibit, which was opened to the public in October, is the most comprehensive on this subject of any in the world.

The second major cause of death in the United States is cancer, which like high blood pressure and hardening of the arteries is on the increase since more people are surviving beyond 40 when cancer takes its greatest toll. Cancer is a disease found in many species of animals and even in plants. A cancer begins as a single body cell or group of cells which for poorly understood reasons start to grow independently and at the expense of the rest of the body. Some one has said that cancer is a wild growth of lawless and parasitic gangster cells. Each of us begins life as a single cell and consists of about 200 billion cells at birth, and of trillions of cells as an adult. Cancer cells have abnormal power to reproduce themselves and as a result cause a tumor or swelling in the body. There are many kinds of cancer, depending upon the type and location of the body cells which take the path of wild, lawless, destructive growth. In women, the most common sites are the breast, the uterus, the skin, the bowel, and the stomach; in men, the most common sites are the skin, the stomach, the prostate, the bowel, and the lung. As a cancer grows, it invades and destroys surrounding tissues and body parts. Particles of the original cancer break off and are carried by the blood and lymph streams to other body parts where new cancers are started. These so-called cancer metastases in turn grow and destroy tissue and otherwise interfere with body functions. The ultimate cause or causes of cancer are presently unknown, although we are acquainted with certain auxiliary or contributing factors. The most important of these is chronic irritation of some body part, such as the lip by a warm, clay pipe. However, many areas of chronic irritation do not develop cancer. The nature of cancer and its tendency to spread to other tissues and organs, makes early diagnosis and treatment of paramount importance. Hence, everyone should know the seven danger signals of early cancer which have been widely publicized by the American Cancer Society. (i) A persistent lump or thickening anywhere in the body, especially in the breast. Many such lumps are not cancer. (ii) An irregular bleeding or discharge from any body opening. (iii) Persistent indigestion, particularly after the age of 40. (iv) Any sore on the body which does not heal promptly, particularly about the mouth. (v) A sudden change in the form or rate of growth of a mole. (vi) Persistent cough, chronic hoarseness, or difficulty in swallowing. (vii) Any significant change in bowel habits, either persistent diarrhea or constipation. Any of these signals may be due to causes other than cancer, but competent medical opinion should be sought. Pain, loss of weight, and general weakness are late signs of cancer. Patients with early, curable cancer ordinarily look and feel relatively or completely healthy. The present methods of treating cancer which are surgery, radium, and x-ray are highly effective in early cancer, but much less so in advanced cancer. The complete conquest of cancer will come only through intensive and extensive biological and medical research.

Arthritis or rheumatism is presently responsible for the physical incapacitation of more people in the United States than any other disease; viz., 7,000,000. Arthritis is not ordinarily responsible for death but does cause varying degrees of discomfort, pain, and disability. There are several types of arthritis which have significance from the medical but less so from the lay point of view. In addition to the pain and disability, certain deformities may occur. Treatment of certain forms of arthritis with

ACTH and cortisone has proved most helpful in some patients. Other types of therapy are also of value. Here again, the causes of the more common forms of arthritis are presently unknown and continued biological and medical research is the only avenue of solution.

We have already mentioned the fact that various infectious diseases may occur in older people as well as in young, and we cited as examples, pneumonia and tuberculosis. Modern medical treatment of both of these diseases is relatively satisfactory and this is particularly true of pneumonia. Indeed, the incidence of death from pneumonia in later as well as earlier years has declined remarkably since the advent of the sulfa drugs and the antibiotics. We have already mentioned that the lungs function less adequately in bringing oxygen to the blood in the lungs due to a decrease in the elastic tissue and other factors and that the respiratory reserve is gradually reduced with age. Sometimes these changes become so pronounced as to constitute a disease known as emphysema. Another condition which is not uncommon in later years is chronic bronchitis, an inflammatory disease of the air passages of the lungs. Both of these conditions respond to medical treatment.

People in later years are sometimes subject to certain diseases of the gastrointestinal tract. These include inflammation of the gallbladder and gallstones, ulcer of the stomach or of the first part of the bowel, dyspepsia, and constipation. Gallbladder disease and sometimes ulcer may require surgery, but the other conditions can be effectively treated medically.

We have already mentioned the fact that the most common nutritional abnormality after 50 is overnutrition or obesity. Obesity is well-known to be associated with an increased incidence of high blood pressure and hardening of the arteries as well as sugar diabetes. Occasionally obesity is the result of a disturbance in the glands of internal secretion such as the thyroid, but mostly it results from eating in excess of body need. Reducing diets which are both palatable and effective are available and should be followed under medical supervision. Certain reducing drugs and pills are dangerous and other preparations and devices are senseless and ineffective. It is unfortunate that our pure food and drug laws are inadequate in relation to this problem and fail to prevent certain flagrant mis-information which is presented to the public through advertising media.

Sugar diabetes, when it occurs in later years, may be due to hardening of the arteries and decreased blood supply to the pancreas which manufactures insulin, one of the important hormones or internal secretions controlling the burning or utilization of sugar and fat in the body. Sugar diabetes in older people is usually mild or moderate in degree and ordinarily well controlled by diet, insulin, and other medical care. Treatment of diabetes is important because untreated diabetes accelerates hardening of the arteries, thereby establishing a vicious circle.

In closing our discussion of diseases of later years, we emphasize the fact that when symptoms and signs of disturbed health appear after 50, they should not be considered as part of the aging process and disregarded. Frequently, such complaints are due to disease which can be cured, controlled, or at least ameloriated by competent medical care.

III. Better Health in Later Years. Some pessimists have pointed out that a life span of 30 years for the human is sufficient to propagate the race and even to permit notable contributions to society. Outstanding examples of those who made notable contributions during such a short life span, of course, are Jesus, Spinoza, Raphael, Mozart, Keats, and Shelley. Moreover, the life expectancy of approximately one-half of the people in the world today, principally those of Asia and Africa, is no more than 30 years. Nevertheless, humans as a rule desire long life and certainly good health. That a long life expectancy can be advantageous to a society is evidenced by the notable contributions which are possible in later years and old age. Conrad, for example, wrote his first novel at 50, Edison continued to invent after 70, Goethe wrote "Faust" at 80, and Clara Barton, the founder of the Red Cross, continued her important work beyond 90. The desire for increased longevity has been apparent through the ages. Several centuries ago, it was expressed in Ponce de Leon's search and more recently in Hilton's "Lost Horizon".

At present, the most important factor in determining our life span is heredity. Indeed, it has been pointed out that one can predict

his life expeetancy reasonably aeeurately by taking the average of the life spans of his four grandparents. The aeeuracy is somewhat increased if the life spans of one's parents can be averaged in. Certain families are long lived, others are short lived. However, it must be emphasized that any given individual may prove to be a notable exception to these generalizations. When we understand the biology of aging better than at present, we may very well be able further to increase the life span of even long lived families. Certainly, there is no question but that a better understanding of the causes, mechanisms, prevention, and treatment of diseases of the heart and arteries and kidneys and of caneer will considerably extend the span of short lived families. It should be remembered that when we say there is an hereditary faetor in the causation of high blood pressure and of hardening of the arteries, we have not explained this factor. Obviously heredity must operate through altering body mechanisms in sueh a way as to bring on these diseases and it is the responsibility of medical and biological researeh to determine what these mechanisms are. Thus we know that hemophilia or bleeder's disease is hereditary but we also now know that the blood fails to clot beeause of the deficieney of a eertain chemical in the blood. When medical seience once learns to eure and prevent high blood pressure, hardening of the arteries, kidney disease, eancer, and rheumatism, the life span of many in the United States will be greatly prolonged with aeeompanying good health.

Our aim in later, as well as in earlier, years should be not only to minimize the ineidenee of disease but also to strive for a maximum of health. In the past, even some physicians have been satisfied with the absenee of disease in their patients. Today, however, there is inereased recognition of the coneept that there are levels of health and that our goal should be a maximum of good health rather than a minimum of disease. Rules of hygiene recommended for the young are even more applicable to older people. They should include attention to the following: adjustment to the environment. nutrition, exercise, sleep, sex funetions, and periodie medical evaluation. Let us eonsider each of these briefly. Proper mental and physieal adjustment to ehanges produced by aging is necessary. Decreases in physical strength, agility, and dexterity are well compensated for by greater experience, better understanding, and sounder judgment. Early childhood training among other faetors plays an important role in determining adjustment to aging. It is also interesting to note that in Raymond Pearl's analysis of 2,000 over 90, plaeidity of temperament was an outstanding quality. Certainly there is evidence that frequent and sustained emotional tensions aceelerate the aging process.

Adequate nutrition is just as necessary as in earlier years. The diet should include sueh foods as milk, meat, fish, eggs, fruits, and vegetables whieh contain important vitamins and minerals. All people, or at least those responsible for the planning of meals, should be familiar with the basic seven food groups and the number of daily servings from each. People of all ages should realize that optimal nutrition cannot be achieved by one good evening meal after a coffee and doughnut breakfast and a soft drink and sandwich luneheon. The idea that a deficient diet can be compensated for by one, two, or three vitamin pills per day must be laid to rest. Too much emphasis can not be placed on the facts that vitamins are best obtained in natural foods, that vitamin pills should be reserved for medieal needs on a physieian's prescription, and that under certain eircumstances vitamin pills may even be harmful. Good teeth or properly fitting dentures are, of course, of considerable assistance in the obtainment of optimal nutrition.

After 50, physical exercise should be moderate in type and amount. For example, it is golf rather than tennis. As a matter of fact, walking is an exeellent form of exercise and the several miles per day whieh most of us aeeomplish in the ordinary routine of things is suffieient. Strenuous exereise is definitely undesirable for men and women over 50, prineipally because of the strain plaeed on the heart and arteries.

After 50, it becomes inereasingly important for the individual to obtain the amount of rest and sleep which is neeessary for his best health and work. With few exceptions the amount of sleep required after 50 remains unchanged even though some physiologists have maintained that the requirement deereases with age. This is

probably explained by the fact that older people are likely to catnap during the day, thus decreasing the number of hours of sleep necessary at night. The restoring effects of rest and relaxation even without actual sleep are considerable and should be remembered when there is occasional insomnia. Persistent insomnia, of course, should lead to medical advice.

We have already referred to the menopause in women and to decreasing sex activity in men after 50. However, the sex function is still important after 50 both in its mild and more overt forms. Even in the sixties and seventies there are needs and desires which should be better understood by the children of widowers and widows who wish to remarry.

A periodic physical examination is more urgent after 50 than before. Prior to 50 once a year may be regarded as sufficient; after 50, once every six months is preferred. If there is evidence that aging is proceeding at too rapid a pace, the physician can offer helpful advice. If incipient disease is present, the physician may either effect a cure or delay the progress of the condition. In any event, it is important to follow medical advice. If such advice includes surgery, there should be no hesitance. With modern preoperative and postoperative care and advances in surgical techniques and anesthesia, even elective or optional surgery such as hernia repair, may be undertaken with complete confidence not only for those of later maturity but even of advanced years.

In closing, may I point out that while the millenium of maximum longevity with optimum health for the human species is far from achievement presently, medical and biological research may place this goal within the grasp of man in a century or less. If and when this happens, it is to be hoped that man will have made comparable progress in the solution of his major social, political, and economic problems. Only thereby can the full significance of maximum health and longevity be realized.

Trichloroethylene in General Practice

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In recent months considerable interest has been created in the analgesic and anesthetic agent "trichloroethylene". Its use in this country is steadily increasing both in anesthesiology and as an analgesic agent in dentistry, obstetrics, and minor surgery. It therefore is timely to survey the properties and applicability of this agent, as well as its limitations and dangers. Our clinical experience with trichloroethylene dates back to 1943 and comprises well over one thousand administrations.

History. Trichloroethylene has been known since 1864, and has long been used in industry for such processes as dry-cleaning, dewaxing of lubricating oils and degreasing of metals. The trichloroethylene used for these purposes is a relatively impure substance, and prolonged exposure was often followed by such toxic manifestations as giddiness, vomiting, optic neuritis, and nerve palsies. The nerve most commonly affected was the trigeminal nerve in all its branches, and based on this fact it was suggested in 1928 that trichloroethylene be tried in the treatment of trigeminal neuralgia.[1] This line of therapy proved to be effective,[2] although it now seems doubtful whether it is due to a specific

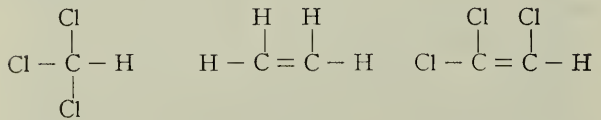
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Published with the approval of the Chief Medical Director, Veterans Administration. Statements and conclusions published by the authors are the result of their own studies and do not necessarily reflect the opinion or policy of the Veterans Administration.

Trichloroethylene used by the authors has been mainly Trimar® which has been generously supplied by Ohio Chemical and Surgical Equipment Co. Earlier experience has been gained by the authors in Great Britain with Trilene®, product of Imperial Chemical Industries. Cyprane inhalers have kindly been supplied by the Ohio Chemical and Surgical Equipment Co. and Duke inhalers by Ayerst, McKenna, and Harrison.

action of the agent on the trigeminal nerve; it rather seems to be the expression of a state of general analgesia which is so marked a feature of trichloroethylene. In 1934 Dennis E. Jackson first suggested trichloroethylene as an anesthetic and analgesic agent,[3] and in the following year he reported favorably on 300 cases.[4] In 1942 Hewer published his first series of 400 cases in Great Britain,[5] and since then the agent has been used in well over one million cases in Great Britain alone. In 1943 Waters, Orth and co-workers[6] reported on the use of trichloroethylene in this country, using it as the sole agent for deep general anesthesia. Their report which stressed the occurrence of undesirable effects on cardiac automaticity was largely instrumental in delaying acceptance of the agent in the United States. The long, vast, and on the whole happy experience of British and later of Canadian anesthetists now compels us to re-evaluate this agent, accepting it as an established fact that trichloroethylene is unsuited as the sole agent for the attainment of deep surgical anesthesia and muscular relaxation.

Physical Properties. Trichloroethylene as commercially available for anesthesia is a highly purified product quite unlike its industrial cousin. It is a colorless liquid, to which is added a blue dye for purpose of identification. Its smell is not unlike that of chloroform, but lacks the pugency of that agent. The drug has been likened to chloroform in many ways, its formula resembling both chloroform and ethylene.



Trichlormethane (Chloroform) | Ethylene | TRICHLOROETHYLENE

With a boiling of 86.9° C at 760 mm Hg pressure the agent is little volatile at room temperature. This makes its administration by the open mask difficult, yet possible. It has a specific gravity of 1.47, and its vapor density of 4.54 makes it 4½ times as heavy as air. One of the great advantages of trichloroethylene is the fact that under clinical conditions it is non-explosive and non-flammable when mixed with air at room temperature, a most desirable and only too rare feature in any inhalation anesthetic agent. When mixed with oxygen, a narrow band of flammability exists, but this is well out of anesthetic range, being approximately 10% trichloroethylene, and may thus be ignored for all practical purposes.[7] However, in the presence of an open flame, diathermy, etc., traces of phosgene are likely to form from the decomposition of trichloroethylene. If inhaled, these breakdown products may prove dangerous. This is particularly so if smoking is the cause of such decomposition, since then the entire breakdown products are inhaled. Trichloroethylene also decomposes in sunlight and if exposed to air; it therefore is supplied in colored bottles and should be kept firmly stoppered and protected from heat and light. In decomposing, trichloroethylene oxidizes to dichloracetyl chloride, with traces of carbon monoxide, hydrochloric acid, and phosgene forming. In order to retard decomposition, 0.01% thymol is added to the product commercially available for anesthetic purposes. Trichloroethylene mixes freely with diethyl ether without chemical reaction, but is decomposed in the presence of soda lime. In this country the substance is marketed under the trade names of "Trimar"® and "Trilene"®.

Pharmacology. Trichloroethylene being somewhat of a hybrid between chloroform and ethylene, one may expect it to exhibit some of the properties of both these agents, as indeed it does. Broadly speaking, it combines the potency of chloroform with the absence, in clinical doses, of viscerotoxic effects which is a feature of ethylene. As with chloroform, the simultaneous administration of epinephrine is not permissible where trichloroethylene is being used, on account of the likelihood that severe cardiac arrhythmias may develop which may even lead to ventricular fibrillation and death. In fact, not only epinephrine but other chemically similar substances should not be used; drugs such as Vasoxyl® and Neo-synephrine® are available for vasopressor effect and may be used.

It will be remembered that all general anesthetic agents, before they cause surgical (stage 3) anesthesia, will make the patient traverse a stage of general analgesia (stage 1) and one of excitement or delirium (stage 2). While the second stage is somewhat under the control of the anesthesiologist and may be modified or totally abolished by adequate preparation of the

patient and by sedation, the stage of general analgesia depends upon an inherent property of the anesthetic agent which is being used. With some drugs the stage of general analgesia is short and ill-defined, while with others it may be produced and maintained with relative ease; such agents are valuable for their analgesic properties from a clinical point of view. Trichloroethylene is one of those which possess great analgesic properties and a wide range of general analgesia. With trichloroethylene it is possible to maintain a state of general analgesia for a considerable length of time for the alleviation of pain or the accomplishment of certain minor surgical procedures. With the establishment of surgical analgesia the patient experiences a feeling of warmth, well-being, and exhiliration; very frequently the whole period of analgesia is blanketed out from the patient's memory by a state of amnesia.

Trichloroethylene is a potent agent, and it is therefore a matter of comparative ease to attain true surgical anesthesia with the drug. Concentrations as low as 0.5 — 1.5 vol. % will suffice. However, only light general anesthesia is indicated with trichloroethylene alone, as in the concentration required for deep anesthesia the drug exhibits certain undesirable features. Muscular relaxation must never be attempted with trichloroethylene alone, but may of course be obtained by the injection of one of the muscle relaxant drugs, or by the addition of some other inhalation agent of sufficient potency and safety.

It has been stated previously that deep levels of anesthesia with trichloroethylene are neither safe nor desirable, and it will now be necessary to consider the pharmacological reasons for this. There can be no doubt that the deeper the plane of anesthesia with trichloroethylene, the more frequent cardiac arrhythmias will be encountered; most commonly these arrhythmias take the form of auricular extrasystoles, but ventricular extrasystoles and ventricular multifocal tachycardia may occasionally be encountered. The latter is usually considered a precursor of ventricular fibrillation, and is therefore an occurrence of grave significance. However, a number of authors have been at pains to point out that when ventricular multifocal tachycardia occurs during trichloroethylene anesthesia, it is by no means a precursor to ventricular fibrillation, as it would certainly be if chloroform was being administered.[8,9] Indeed, the cases of cardiac arrest under trichloroethylene are very few and far between. In 1948 Hewer reported that only two possible cases of cardiac failure had been reported from the use of trichloroethylene,[10] and in these the role of the drug in the causation of the disaster had been far from clearly established. In a recent British analysis[11] of 400 deaths associated with anesthesia of any kind, only 4 (or 1%) were associated with the administration of trichloroethylene; no data are given in this analysis concerning the patients' condition, type and length of operation, depth and management of anesthesia. But even without this information the relative harmlessness of trichloroethylene is evident, as only 1% of all deaths were associated with this agent which is almost certainly used in more than 1% of operations in Great Britain.

Another undesirable feature of trichloroethylene, especially if the drug is administered in high concentrations, is the occasional occurrence of marked tachycardia and tachypnea. The exact etiology of this tachycardia is still not precisely understood. The tachypnea is believed to be due to sensitization of the Hering-Breuer reflex. On rare occasions tachycardia and tachynea may occur during light anesthesia, or may be associated with some degree of oxygen lack or carbon dioxide excess. The condition may be relieved by lightening anesthesia and by improving tissue oxygenation; on occasion, however, it may persist despite these measures, and it then becomes necessary to effect a change-over to some other drug or technique. Ether is very satisfactory in these cases, and it is a strange fact that when trichloroethylene administration is again resumed after the interlude with ether, tachypnea does not usually return. Bradycardia and arrhythmias are associated with overdose; Bradycardia denotes myocardial depression.

Induction of anesthesia with trichloroethylene is both rapid and pleasant, it having practically no irritating effects on the respiratory passages in clinical concentrations. Salivation is not increased, and nausea and vomiting are conspicuously absent. One case of liver necrosis has been recorded in the literature[12] but the role of trichloroethylene in this complication was at least doubtful. Trichloroethylene has so often been compared with chloroform that it is necessary to stress that in animal experiments it has



Figure 1: The Cyprane Inhaler.

proved less toxic than chloroform; [13,14] it has also been stated that its toxic effects on the liver are not only less than those of chloroform, but also less than those of ether.[15] Renal function is not significantly changed, and disturbances of metabolism do not seem to exceed those generally associated with general anesthesia. Changes in blood pressure are neither significant nor consistent, but capillary oozing is reduced, and is rather reminiscent of what used to be seen under chloroform anesthesia. Trichloroethylene is eliminated unchanged from the body, mainly through the respiratory tract. Recovery from anesthesia is usually rapid, although traces of the drug may still remain in the blood stream after full recovery has taken place. However, it must be remembered that trichloroethylene is a lipophilic agent; after prolonged or unduly deep anesthesia, the more saturated fatty tissues, releasing the agent slowly, will tend to maintain a higher blood level after administration has been discontinued. Hence, recovery will be proportionally delayed.

Analgesia with Trichloroethylene. For the purposes of general practice, trichloroethylene is outstandingly indicated when used as an analgesic agent because of its remarkable safety and portability. For analgesia, a trichloroethylene — air mixture is usually administered. This can be done most conveniently by means of a special inhaler. A great number of such instruments have been designed; of these the Cyprane and the Duke inhalers are the ones most popular in this country at the present time. (See figures) Analgesia can also be achieved by means of the open drop technique, but because of the low volatility of the drug this method is somewhat more cumbersome, difficult and hazardous and much less precise. In the Cyprane and Duke inhalers, and in most of the other types which have been constructed from time to time, air is being drawn over a quantity of trichloroethylene. The amount of air which passes over the surface of the drug is regulated by means of a dial; the remainder of air is by-passed direct to the patient. These inhalers deliver concentrations which are analgesic for the average patient under average climatic conditions, but are capable of producing light general anesthesia in the full-on position. Each inhaler is provided with means of locking the dial in the position which has been found to be satisfactory for analgesia in a particular patient, thus anaglesia may be self-administered by the patient who cannot by himself alter the concentration of the anesthetic agent. All inhalers are suitable for self-administration of analgesia; should anesthesia supervene, the mask or the in-

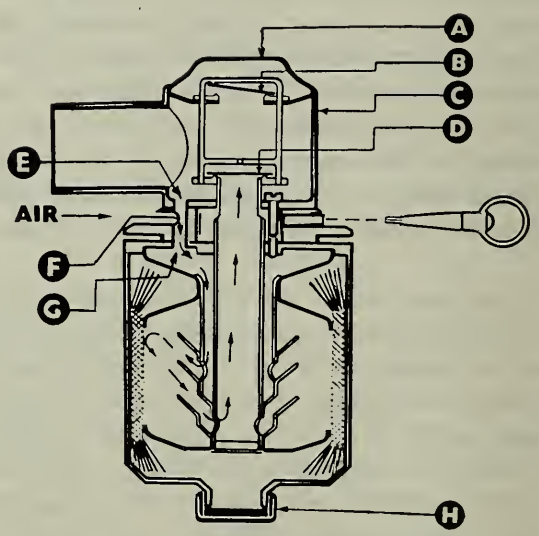


Figure 2: The Cyprane Inhaler (schematic cross-section). As the patient inspires, air is drawn through the holes in the mixture-adjusting collar F. It is then directed down into the Trimar chamber through slots in G, as shown by the arrows, or directed upwards to the face piece through slots in E, or through both, depending upon the setting of the mixture-adjusting collar. Rotation of the mixture-adjusting collar alters the relative areas of opening of the ports in G and E, and consequently more or less air bypasses the Trimar chamber. On expiration, the gases are directed to the atmosphere through the valve B and holes in the side of the cover A. The expired gases are prevented from passing through the Trimar chamber by the non-return valve D. C indicates valve housing tube.



Figure 3: The "Duke" University Inhaler

haler will slip from the patient's grasp; he will therefore then breathe air only and will promptly regain consciusness. Those inhalers which are being held in the patient's own hand, such as the Cyprane and the Duke models, may be strapped to the patient's wrist, protecting the instrument from damage if it should slip from his grasp. Analgesia of this type can be maintained for any reasonable length of time without fear of undue deleterious effects upon the patient. No rebreathing takes place where the analgesia inhalers are used; hence carbon dioxide accumulation does not occur. Air being drawn over the analgesic agent, hypoxic concentrations are likewise avoided. The importance of length of administration and dosage has been mentioned previously; it follows that as analgesia is long continued, smaller concentrations of drug will be required to maintain the analgesic state. It must also be remembered that trichloroethylene passes the placental barrier, and may therefore be the cause of some drowsiness of the newborn if administration of the agent has been very prolonged and continuous.

Trichloroethylene analgesia finds a great variety of uses. Among the more important are the relief of pain during the first stage of labor, dental and minor surgical procedures; as examples of the latter the following could be cited: change of painful dressings, incision of thrombosed hemorrhoids, myringotomy, cystoscopy and other endoscopic procedures, painful examinations, suture of small and superficial lacerations, manipulation of minor fractures, supplement to local and spinal anesthesia, etc., provided epinephrine and similar drugs are avoided. The method is particularly useful in office practice where general anesthesia for these and similar procedures presents great difficulties and is attended by hazards not encountered if consciousness and reflex activity remains unimpaired, as is the case in general analgesia. Also, the portability of the inhaler makes for easy use under emergency conditions outside the office.

General Anesthesia with Trichloroethylene. The use of trichloroethylene for general anesthesia is somewhat beyond the scope of this paper, as it falls within the domain of the anesthetist or anesthesiologist. It is an operating room procedure, except in those rare instances where adequate facilities for general anesthesia are available in a physician's or dentist's office. The subject will therefore be only touched upon in this discussion.

Owing to the absence of irritating effects upon the respiratory tract, induction of anesthesia with trichloroethylene is both fast and pleasant unless concentrations are increased with undue

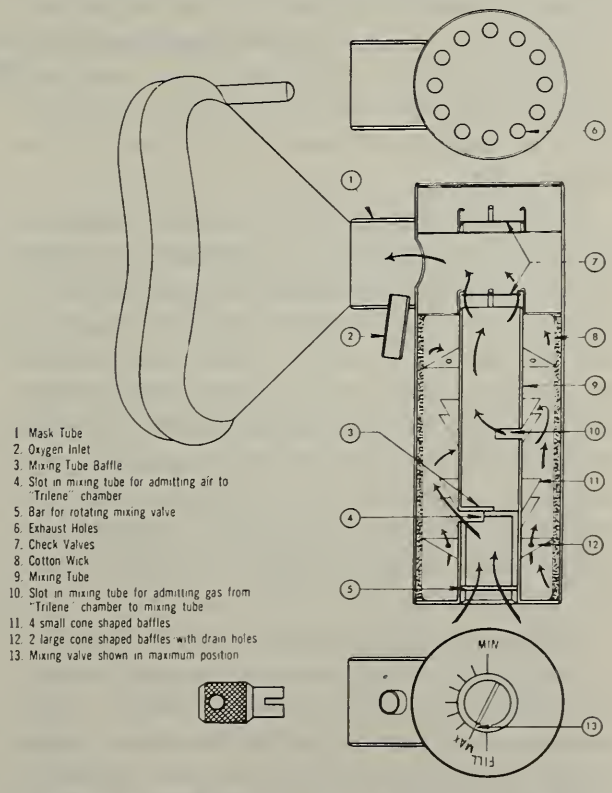


Figure 4: The "Duke" Inhaler (schematic cross-section).

rapidity. Emergence from anesthesia is likewise quick if undue depth of anesthesia or very long administrations are avoided; the reasons for this have been previously discussed. Emergence also is not commonly attended by unpleasant side effects. Salivation is minimal, even where belladonna derivatives have not been administered.

It should be recalled that trichloroethylene reacts with the soda lime of the carbon dioxide absorption unit of closed circuit anesthesia; hence, the closed circuit technique cannot be employed. This will necessitate the adaption of most anesthetic machines to a non-rebreathing system. The use of epinephrine and similar drugs is to be avoided.

Trichloroethylene is hardly ever indicated as the sole anesthetic agent, but rather should be used as an adjuvant to some other general anesthetic. The fact that it is non-explosive renders it eminently suitable as an adjuvant to nitrous oxide. Very limited amounts of the drug (0.5-1%) will suffice and will enable one to maintain nitrous oxide anesthesia with 30 and even up to 50% oxygen. Thus the threat of hypoxia is removed from nitrous oxide anesthesia; an even level of anesthesia can be kept throughout; yet, recovery is not markedly delayed. Such anesthesia is of course not limited to situations of explosive hazards, but may be used where ever a light plane of anesthesia will suffice for the operation at hand. Relaxation, where required, may be obtained by the use of muscle relaxants, or by a change to a more potent agent such as diethyl ether.

It must be emphasized that nitrous oxide anesthesia still is intended as the main anesthetic agent, and that trichloroethylene only serves the subordinate role of stabilizer and potentiator of the nitrous oxide anesthesia. The total amounts of trichloroethylene used are very small indeed, and recovery from anesthesia is little prolonged when compared with mere nitrous oxide-oxygen anesthesia. One thus enjoys all the many advantages of nitrous oxide anesthesia without having to endure its disadvantages and without adding undesirable factors to the anesthesia.

Trichloroethylene anesthesia as just described is suitable for a large variety of surgical procedures. These include those mentioned when analgesia was discussed, and many others in addition. As instances one may mention operations on the extremities, incision and drainage of abscesses, gynecological examinations and obstetric procedures not requiring profound relaxation, tonsillectomy, circumcision, orthopedic manipulations, debridement and suture of lacerations, plastic operations, and many more. If muscle relaxants are administered, the number of indications is correspondingly increased, provided that reflex stimulation associated with any particular procedure does not demand a deeper level of anesthesia. Thus it will be seen that the indications and uses of trichloroethylene are indeed legion, and when wisely used, an agent is available in it which has much to commend it. Administered with nitrous oxide, the record of safety of the drug over the past decade in Great Britain is most impressive indeed and warrants our close attention.

CONCLUSIONS

Trichloroethylene is relatively new to the United States, but it is an anesthetic agent of great possibilities. In its favor are the following facts:

1. Marked analgesic properties;
2. Non-flammability;
3. Rapid induction and recovery;
4. No increase in bleeding;
5. No increase in salivary flow;
6. No viscerotoxic properties in the doses recommended;
7. Rarity of post-operative nausea and vomiting;
8. Portability of analgesic equipment;
9. Ease of management of analgesia;
10. Cheapness of the drug.

The following are the principal disadvantages and limitations of trichloroethylene:

1. A high boiling point rendering the open drop administration difficult;
2. Inadequate muscular relaxation within the range of safety;
3. Decomposition in the presence of soda lime precluding the closed circuit technique;
4. Occasional occurrence of tachypnea and tachycardia;
5. Incompatibility with epinephrine;
6. Potency and potential visceral toxicity in excessive doses.

Fortunately none of these disadvantages are of a serious nature and none interfere with the inherent safety of trichloroethylene for analgesia and light anesthesia, and as a supplemental agent for other drugs. Recognizing these definite limi-

tations of trichloroethylene, the agent becomes one of the most useful additions to anesthesia for many years past. Its record of safety in the experience of British anesthetists is truly unequalled by any other agent, and we may do well to profit by the experience gained by our colleagues in the British Isles. Trichloroethylene has much to recommend it to the attention of general practitioners and dentists for the procedures outlined in this paper.

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ACTH and Cortone in Eye Diseases

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The local *use* of cortone in eye diseases was first reported at the meeting of the American Ophthalmological Society in June 1950. Dr. Alan Woods reported that cortisone solution, instilled locally into the eye, had been strikingly beneficial in checking inflammation in eight cases of anterior segment and conjunctival disease. In addition, experimental proof was given that this type of treatment effectively blocked inflammation in the eye due to protein agents, bacterial antigens, and tuberculin as well as that caused by injecting glycerine and jequirity into the anterior chamber. The inflammation was blocked very effectively, altho the effect was temporary. The importance of these facts is obvious. Only a small amount of the *drug* need be used, so the cost to the patient is low and hospitalization is not required. Moreover, the normal secretion of cortone by the adrenals is neither suppressed, as it is when cortone is *given* internally, nor increased as it is with ACTH, hence there are no undesirable side effects.

A few months after Dr. Woods' report both cortone and ACTH became available to everyone. We are now well on our way to finding out what place these products are to have in the treatment of eye diseases as well as what difficulties may arise from their use. They are potent, and when administered internally in too large a dose and for too long a time, can cause considerable harm. A complete discussion of this subject belongs in the field of internal medicine, but the ophthalmologist must have a practical working knowledge of it, or he should not undertake treatment without help from an internist. There have been

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a few changes in the method of administration and dosage since the *drugs* first became *available.*

Cortone for local *use* may be *employed* full strength or diluted with normal saline, (one part cortone to two parts saline, or, as is usually done because it is well tolerated, one to four). Cortone for local *use* is available also as an ointment and may well be applied just before retiring to produce continued action during sleeping hours. The label on the bottle of the solution should be marked "shake" and it is important that the patient be instructed to do so. In severe cases the solution should be *used* every hour until improvement is obtained, then reduced to every two hours. Cortone locally may be continued as long as desired; and in vernal conjunctivitis and sympathetic ophthalmia it often is *used* for months.

Subconjunctival injection of a few drops of full strength cortone acetate solution is permissible if increased *effect* is desired, as in cases of interstitial keratitis, sclerosing keratitis, and posterior uveitis. It can be repeated when the amount previously injected is absorbed, which varies from three to ten days. No serious systemic reactions have been observed from subconjunctival injection.

ACTH is usually given intramuscularly every six hours, starting with 10 U.S.P. units every six hours for several days. If no clinical *effect* is noted, the dose may be increased to 20, or even 30 units, but it should be reduced to 10 units as soon as *possible.* In general, infants and young children require a larger dose per kilo of body weight than do adults. If high doses are needed or if edema develops a low sodium diet with increased potassium intake is advisable. In general the side *effects* are reversible, but caution is essential in giving ACTH or cortone to patients with hypertension, congestive heart disease, or diabetes, or in the *possible* presence of any acute suppurative disease of the gall bladder or appendix. Peritonitis may develop without our knowing it. The eosinophil count should be made every few days to keep track of the degree to which these cells are decreased. When the eye has recovered the dose of ACTH is reduced gradually rather than stopped abruptly.

Cortone may be given intramuscularly or by mouth. Formerly the suggested dose was 300 mg. the first day, 200 mg. the second day, and then 100 mg. daily. This probably was more than necessary. Now the usual dose is 100 mg. daily, 25 mg. every six hours. It is important to remember that when cortone is *given,* the adrenals largely cease to produce cortone. Therefore, the dosage should be reduced gradually and it may be well to *give* a little ACTH when cortone is discontinued. The same care must be exercised with cortone as with ACTH. Cortone or ACTH probably can be *used* for ten days without ill *effects.* This is often all that eye cases need.

It is important also to evaluate both the good and bad *effects* of these *drugs* upon the eye itself Inflammation of the eye as of other organs, begins with congestion, edema, swelling, transudation of fluids, and influx of lymphocytes or leucocytes. These changes help to dilute and destroy the causative agent. If the disease is severe, necrosis may occur. With healing, edema and congestion disappears and leucocytes migrate away; but some fibrosis and scarring may take place. In many eye diseases, loss of vision is *caused* by adhesions and membranes resulting from fibroplastic reaction such as corneal scarring, posterior synechia, or cyclitic membrane. To a *considerable* extent active inflammation is beneficial in overcoming infection but harm follows if the fibroplastic healing stage is overdone. When the disease is caused by bacteria, the inflammatory reaction is blocked by ACTH and Cortone, the organisms may have a better chance to develop than if no treatment were used. However, in the later stage of inflammation, the hormones may reduce fibroplastic formation enough to be of value. This concept may explain why the hormones are at their best in allergic conditions and in inflammations not *produced* by pyogenic organisms. It also indicates that in suppurations, antibiotics may be *used* along with the hormones. The concept of cortone and ACTH inhibiting fibroblast formation is controversial but the degree to which such inhibition occurs probably is not great. There are other instances of the harmful *effect* of cortone on the eye. Ormsby, Dempster, and Van Rooyen found that in experimental herpetic keratitis, moderate doses of cortone did no good and larger doses were harmful.

During the past two years the authors have treated approximately 175 patients with these drugs, the great majority receiving cortone drops

locally. The *results,* which coincide with those of other observers, are as follows:

1—Diseases of the Eyelid. Atropin dermatitis *responded* well to local cortisone. No benefit in contact dermatitis or chalazion.

2—Disease of the Conjunctiva. *Excellent response* to local cortone in allergic conjunctivitis (drugs, cosmetics, etc.), phlyctenular keratitis, vernal conjunctivitis, burns of the conjunctiva, and in staphylococcal and pneumococcal conjunctivitis.

3—Diseases of the Sclera. Episcleritis *responded* extremely well to local cortone; all recovered in a few days. A few *cases* of deep scleritis and sclerosing keratitis *responded* well, but more slowly.

4—Diseases of the Cornea. The *results* in corneal disease were difficult to evaluate. *Results* with local cortone were good in phlyctenular keratitis, epidemic kerato-conjunctivitis, recurrent erosion of the cornea, and in marginal catarrhal ulcers. In dendritic ulcer the *results* in some *cases* were extremely good, but in a few, the opposite was true; in one, a secondary infection occurred which caused hypopyon and almost perforated the cornea. In suppurative keratitis, local cortone makes the eye more comfortable in the early stage but probably is harmful later. However, it is of *considerable* value after the healing stage is well started. There is much variation in the reports in the literature on the *effect* of cortone on corneal diseases. Some observers report *excellent results,* others are opposed to its *use.* The problem is far from settled. Interstitial keratitis *responded* well when subconjunctival injections of cortone were combined with large doses of penicillin. Old corneal scars and corneal dystrophies were not helped.

5—Diseases of the Uvea. Non-granulomatous iritis *responded extremely* well to local cortone in all instances. In a few *cases* in which rheumatoid arthritis was present, the patients also received cortone internally. A few recurrences were observed, but continued treatment was effective. One case of tuberculous nodular iritis did not *respond* until PAS and streptomycin were *given* concurrently. Disease of the posterior uvea were treated by ACTH or cortone internally. The *results* were *excellent* in acute choroiditis. Some improvement was obtained in a few cases of senile disciform macular degeneration. There was no benefit in retinitis proliferans. The *results* in sympathetic ophthalmia are better by far than with any other form of treatment, but some *cases* remain difficult. It is *possible* now to operate on sympathetic ophthalmia without getting the severe post-operative reaction formerly dreaded. We recently had an unusually severe *case* in which iris bombe, glaucoma, and cataract occurred as complications. Three iris transfixations, one iridectomy, and a lens extraction were done. ACTH was necessary for almost a year, so that Cushing's syndrome *occurred,* but the child can see.

6—Diseases of the Lens. No *effect* has been observed on the *cataract* when eyes with *cataracts* were being treated for co-existing disease. No attempt has been made to treat *cataracts* alone.

7—Glaucoma. Primary glaucoma has not responded to local cortone. In secondary glaucoma, due to uveitis, *response* has been good to both local and systemic cortone. In the glaucoma phase of retrolental fibroplasia, local cortone is helpful in making the eyes more comfortable. In glaucoma secondary to thrombosis of the central vein, local cortone is of great value in making the eye comfortable, but has no *effect* on tension or on new vessel formation in the iris.

8—Retrolental Fibroplasia. We have *used* both local cortone and ACTH internally in many of these *cases.* In two, the retrolental membrane became smaller when ACTH was *used.* In most patients no influence was observed.

9—Diseases of the Retina. As a rule no effect is obtained with ACTH in retinitis pigmentosa, but a few *cases* have been reported in which there was real benefit. We have had one *case* in which the child had to be taken out of a sight-saving class and put in a braille class. After treatment with ACTH his vision improved in the right eye from 15/200 to 20/100 and in the left from 2/200 to 10/200. He was transferred back to the sight-saving class and is doing well. In this case improved vision was not observed until several weeks after treatment was given. This is often what happens when diseases of the posterior segment are treated.

10—Intraocular Surgery. Much help can be obtained from cortone and ACTH after intraocular surgery. It is especially valuable after trephine and iris inclusion operations to reduce the low grade iritis that often occurs and to

prevent scar tissue from closing the trephine opening. After cataract extraction, cortone drops should be used *after* the fourth or fifth day if the eye is unusually congested. When cataract must be removed from an eye which has had iritis or if the patient has rheumatoid arthritis or in children with Still's disease who have polyarthritis, iritis, and secondary cataract, it is wise to start ACTH before operating, continue it after the operation, and it is perfectly feasible to start local cortone drops 24-48 hours after operating. With multiple sutures closing the incision, the risk of opening the eye every hour is less than the risk of severe iritis which usually ensues if these hormones are not used. We have not found that wound healing is delayed in any important degree when sutures are used.

SUMMARY AND CONCLUSIONS

Cortisone locally is extremely effective in blocking inflammation of the anterior half of the eye. For inflammations of the posterior segment, cortone or ACTH internally should be used. Further study is needed to evaluate the effect in corneal diseases and in retinitis pigmentosa.

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Eye Changes Due to Advanced Age

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The wording of the respective assignments in this symposium may create the impression that the ophthalmologist spends a good part of his professional life in the upper stories of an ivory tower classifying, cataloguing and correlating ocular changes, while the surgeon and the internist grapple with the real problems of acute catastrophic disease. To correct this impression the following discussion will center around those ocular changes due to advanced age which give rise to ophthalmological problems. Functionally insignificant tissue changes will be mentioned only for the purpose of greater contrast between disabling and non-disabling tissue changes.

An excellent example of the latter is the widespread atrophy of fatty, fibrous and elastic tissue in all the adnexa of the eyeball that make up the characteristic physiognomy of the elderly. From its origin in the region of the eyebrow, the upper lid recedes deeply into the orbit and then comes forward to rest on the eyeball and to cover a larger than normal portion of the cornea. The lower lid loses a good part of its support and elasticity and becomes overly relaxed and flaccid. The normal pump action of the musculature surrounding the tear passages is impaired. The stagnant tears overfill the conjunctival sac even though the senile lacrimal gland produces less than the normal amount of fluid. But no serious disturbance of the lid functions results from this senile atrophic process. Nor does any disturbance of function arise from a change characteristic of the oldest age group, the so-called hyaline plaques in the sclera.

The principal ophthalmologic problem due to advanced age is diminution or distortion of vision. The two main factors in this diminution are senile cataract and senile degenerative diseases of the central portion of the retina. Cataract in the usual sense denotes a state of abnormal turbidity or opacity of parts of the lens. Omitting congenital opacities and acquired ones due to definite, well-established etiologies, opacities of the lens occur with a characteristic age

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incidence which rises from zero at birth to 100% at the age of 80. The rate of increase in frequency is slow up to the age of 40 and more rapid from thereon. While heredity and environment probably play a part in the development of these lens opacities, age is obviously the strongest, the predominant factor. A good many of these opacities cause no or minimal subjective symptoms so that the ophthalmologist who happens to see them during a routine check-up, is often in a quandary whether or not to mention their presence to the patient. Lens opacities of this general type, but of a magnitude sufficient to make the patient conscious of a diminution of vision constitute senile cataract in the clinical sense. The incidence of senile cataract in the clinical sense is not accurately known but probably starts from 0% at the age of 40, rises at first slowly and then more rapidly to reach a frequency of about 50% at the age of 80.

The morphology as well as the clinical course of senile cataract is fairly characteristic. The distribution and the mode of progression of the lens opacities follow well-established patterns which distinguish senile cataract from most of the cataracts due to other causes. Senile cataract is a characteristic senile change in most domestic animals.

The conditions under which the cataract develops seem simple and amenable to the investigative approach. The lens can be removed surgically and the fluid surrounding it can be aspirated with only a slight and temporary disturbance in the function of the surrounding tissues. It seems like an ideal set-up for the study of the aging process. In the words of one of the very active workers in this field "the analysis of this subject is still in the observe and record stage the fundamental processes which cause these changes are still a matter of speculation" (Harris, J. E. Lectures in biochemistry of the eye. the Lancaster Course, Portland, Maine, 1951.)

Like the senile changes of the skin, the cataract is a rather conspicuous manifestation of age. Clinical examination of the affected eye, before and after cataract surgery, reveals signs of senile involution in other ocular structures. Thus. senile cataract probably represents the most easily noticeable manifestation of a rather widespread involutional process due to age.

What are the problems arising out of the development of senile cataracts? While the visual disturbance varies greatly as to the type and severity, two characteristic visual difficulties are most commonly mentioned in the patient's complaints. Depending upon the location of the opacities within the lens the visual impairment is more pronounced under conditions of indoor near vision or of outdoor distance vision. In the former situation the patient finds it difficult to recognize fine detail such as newsprint or small figures under lighting conditions over which he has control. Outdoors the patient is particularly bothered by lights "shining right into his eyes". At the same time the details of the outside world, that is bus numbers, street signs and peoples' faces appear blurred and distorted. The degree of blurriness and distortion varies depending upon the position of the light sources in relation to the patient. Such a visual disturbance is apt to give the patient the feeling of insecurity and unfitness for outdoor life although the same patient in the eyedoctor's office with the light well concentrated on the Snellen chart may still read 20/20 or 20/30. The patient with early senile cataract is usually happier in his home where he can regulate the direction in which the light enters his eyes so as to imitate the conditions during his vision test in the eyedoctor's office. The progressiveness as well as the variability of all these disquieting symptoms is an aggravating factor.

On the basis of my own experience I regret to state that I know of no effective non-surgical treatment for the progressive forms of senile cataract. The temporary improvements that may occur during periods of non-surgical treatment can be matched by similar improvements occurring while the patient is receiving no treatment of any kind.

The advanced age of the cataract patient does not constitute a problem in the surgical treatment of the condition. I am not aware of the existence of any data indicating that the results of cataract operations are in any respect poorer in patients of the age of 85 than in patients of the age of 65. While it is true that we are still not entirely satisfied with the present techniques of cataract extractions and are constantly working on refinements of these techniques the fact remains that with very different techniques and in the hands of very different surgeons the task

of removing a cataract and of restoring free channels for the passage of light through the eye is accomplished in close to 90% of all operations undertaken. Cataract incisions while located, for the most part, in an avascular tissues, heal as a rule just as well in individuals at the age of 85 as they do in individuals of 60. Ocular or systemic complications arising in patients of advanced age either during surgery or during the postoperative period have become rare, especially since the introduction of corneoscleral sutures, of prophylactic treatment with antibiotics and of ambulatory treatment from the second or third postoperative day on. Due to the steady increase in life span of the population of the United States the number of cataract operations performed per annum seems to be on the increase although, through negligence of mine, I am not able to back this up with any statistical figures today. It is certain however that the manufacture and sale of cataract lenses has been on the increase.

This brings me to one of the major problems in connection with senile cataract, the dependence of the operated patient upon lenses which very profoundly disturb the patient's rapport with the outside world. The fundamental factor in this disturbance is the enlargement of the retinal images by the cataract lenses. A patient who during 60 years of his life has learned and become used to a certain relationship between the size of retinal images and the other sources of information concerning the outside world, suddenly finds himself in a state where tactile and visual impressions no longer jibe. Objects appear very much closer than they actually are, seriously upsetting a judgment of distance acquired and found reliable throughout 50 to 60 years of pre-cataract life. The following is a quotation from an editorial "The adjustment to aphakia" (Am. J. of Ophth. 35:118,1952.) written by an ophthalmologist who had undergone successful cataract extractions on both of his eyes and had made as complete an adjustment as possible: "An unpleasant phenomenon encountered by the new aphakic is spherical aberration. At first it appears almost impossible to live in a world in which all straight lines are transformed into curves and a linear and upright world is suddenly converted into one of parabolas. This difficulty is augmented when he discovers that the movements of his eyes, which were part of his former existence, suddenly cause the curved outside world to squirm like writhing snakes. Thus the newly elected aphakic regards a door through which for years he has been accustomed to pass without misadventure and, to his amazement, he finds the jambs on each side curve in toward the middle and leave an aperture only a few inches wide at the center, through which all reason tells him it will be impossible to wedge his portly person.

When mature thought finally persuades him that this is an optical illusion and he timidly advances to make the test, he finds to his delight that as he approaches the opening, the curves recede gracefully and invitingly to his approach and he finds easy and unimpeded passage.

Similarly, when entering a high room with tall columns such as hotel lobby or a railroad station, he finds the supporting columns bending and waving precariously and he is immediately convinced that by trespassing in such a manifestly shaky edifice, he will accentuate the instability and invite disaster. He fears that he will emulate Samson at Gaza, where in revenge for the loss of his own eyes, Samson precipitated the entire structure on the heads of jesting Philistines, and incidentally upon his own!

Gradually he learns the secret of persuading the outside world to remain in a properly upright position and abandon its sinuous behavior. The secret consists in holding his eyes motionless, his gaze fixed through the optical center of the correcting lens, and to move his head slowly to look at any desired object not in his direct view. When this simple trick is mastered, the spherical aberration disappears, and, once gone, can only be elicited and reproduced with difficulty."

A good many of the problems posed by the development of senile cataract can be solved to the patient's satisfaction. There are a good many cases in which the problem is solved by settling for a somewhat imperfect vision through a mild, fairly stationary cataract. The physician's part is to help the patient size up his professional and psychological handicap and his unhappiness resulting therefrom and to weigh this handicap carefully against the disadvantages of aphakic life. The ophthalmologist's part consists of estimating the future course of the lens opacities, stationary, slowly progressive or rap-

idly progressive.

A much more serious problem is posed by the senile atrophic and degenerative changes affecting the central portion of the retina. Strictly speaking they have to be classified as diseases of the aged since they are the consequence of local arteriosclerosis. Its mildest form, senile macular degeneration, is a common cause of failure of central vision in the old people of the U. S. A. The condition usually starts unilaterally but the other eye almost invariably becomes affected within a period of a year. Primary changes are found in the choroidal circulation which show marked sclerotic changes and degeneration.

It is a situation in which a common and widespread vascular disease of old age causes the most conspicuous and disabling manifestations, in the realm of vision. Most of the individuals appear to be in good health and their principal trouble is the impairment or complete loss of central vision. The incidence of this disease in the population of the middle west is not definitely known. About one-third of the elderly applying for blind assistance in the State of Illinois have suffered a reduction of vision below the level of 20/200 as a result of senile macular degeneration. One redeeming feature of the disease which the physician should stress in counselling the patient, is that it does not lead to blindness, the patient retaining a normal field of vision except for a central scotoma of varying size.

The treatment of senile macular degeneration is extremely unsatisfactory because of the unusually high circulatory requirements of the retina and because of the truly sclerotic and progressive nature of the underlying choroidal disease. Vasodilators rarely ever produce lasting improvements. ACTH or Cortisone administered during edematous phases of the disease may bring about temporary improvement without changing the outcome. It is my feeling therefore that these drugs are not indicated.

In the very early stages of the disease when the vision is still 20/40 or better microwave diathermy has been found of value by W. B. Clark (Transactions Am. Acad. of Ophth. & Otolar. 56:600, July-August 1952). That is about the only ray of hope that I can see now. In most cases, however, the treatment is limited to trying to conduct the patient's life into channels where his loss of central vision is less acutely felt and where satisfaction can be derived from work not requiring central vision. As stated so very aptly by Duke-Elder many of these patients "can be helped only insofar as every effort should be made to assist them and accommodate their interests with philosophy and resignation to their limited visual efficiency. "The inability to read may call for a talking-book machine or the help of a reader. The patient's normal range of vision should permit him to move around on foot almost as freely and safely as a normal sighted person.

The term presbyopia would lead one to expect that it is a change due to advanced age. The underlying process is the hardening of the central, that is the oldest portion of the crystalline lens which gradually increases the load against which the muscle of accommodation has to work. The process starts as birth and continues from there at a very steady rate. The clinical manifestations, limitations of near vision, do not set in until the hardening of the lens has reached a certain magnitude which usually happens at the age of 40. The name presbyopia and the implication that it is a sign of advancing age, makes some people reluctant to accept presbyopia and the help afforded by glasses. Such people, are "bothered and annoyed by their glasses" because of their unwillingness to accept any or all signs of advancing years. In general, however, presbyopia presents no ophthalmological problem.

Practical Details in the Removal of Foreign Bodies from the Eye

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Many foreign bodies entering the eye may be removed without difficulty. Nevertheless certain problems exist in each case which help or hinder the surgeon during their removal. In the last ten years I have had the opportunity of removing many intra-ocular foreign bodies and from this experience I shall present some data which I hope may be of some help to all.

Foreign Bodies Deeply Situated In The Cornea:—Small deeply embedded foreign bodies in the inner third of the cornea and too small to be removed under the naked eye or loupe are removed under direct observation with the slit-lamp. The foreign body is loosened from its bed with the fine point of a Ziegler Needle Knife and then gently teased out or pulled out by the magnet. The exuding of tissue fluids may obscure the foreign body, and then it has to be removed on repeated attempts. Or, during the process, a perforation of the cornea, and a collapse of the anterior chamber may take place. Such a foreign body should be then removed after the anterior chamber has reformed, and not immediately.

Foreign Bodies In The Anterior Chamber:—The removal of foreign bodies lying loosely in the anterior chamber, always appears to be easier than is the case. One realizes this to be a fact, when he is in the midst of the attempted removal. Therefore, it is best to map out the procedure before starting, remembering, that it is essential to allow for plenty of working space. The anterior chamber is usually formed, because the opening made by the small foreign body in its passage through the cornea, is sealed over rapidly. It is best to make a large incision at the periphery of the cornea nearest the foreign body. Sometimes this incision can be as long as that made for a cataract extraction.

When the anterior chamber is shallow, one is compelled to make an ab-externo or scratch incision, and then to enlarge the opening with the corneal scissors. Sometimes, immediately after the initial trauma, the pupil responds poorly to atropine or esserine, and, the size of the pupil cannot be controlled. Then, in attempts at removal with the magnet, it is possible to displace the foreign body by pulling it through the pupil and under the iris or, into the chamber angle. The procedure may become very difficult, because the foreign body may become locked in the deepest recesses of the angle or somewhere under the iris. If the operator works slowly and carefully, it is not necessary to remove a sector of iris, with the removal of the foreign body.

Foreign Bodies Situated In The Lens:—The opening in the lens closes over rapidly and localized changes take place that might remain stationary or progress to a complete cataract. If the foreign body is small, and located at the periphery of the lens, and does not interfere with vision, it may be left alone. However, if it is located near the center of the lens, and interferes with vision, then, it is best to consider the removal of the foreign body and the lens after the inflammatory reaction which exists, subsides.

If the foreign body is large, and located within the lens, one may defer its removal until the lens becomes opaque — after which time the foreign body can be removed at the same time as the cataract. The swelling of the lens which may follow, may cause the development of a secondary glaucoma. The lens in such cases should be removed before the secondary glaucoma becomes severe.

Foreign Bodies Located In The Anterior Segment Of The Vitreous:—The size of the foreign body is usually small and it may possess some degree of magnetism. In such instances, the sclera and ciliary body is incised with the point of a thin sharp cataract knife by making

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short clean incisions at the site where the foreign body is to be removed by the magnet. There is little bleeding and the resulting wound heals without much reaction. If the foreign body is not too small, and can be easily obtained, it is best to make the incision through the pars plana of the ciliary body.

Foreign Bodies Of Borderline Location:— Many times it is impossible to determine the exact location of the foreign body after repeated reliable localizations are attempted by different roentgenologists. One cannot decide whether the foreign body is inside or outside of the eyeball. This indecision results from the fact that, eyes vary in size, and this variability in size causes an error of about 2mm. either way from the sclera. When such a situation exists, the region of the eyeball in the area which is involved, should be explored by direct inspection for any telltale contusions or perforations, and for the foreign body itself. (The Berman Locator is of great help in this situation since it helps reassure the operator that the foreign body is located in the area explored.) If no foreign body is found, one makes an opening in the sclera at the point closest to where the foreign body is supposed to be, and then, attempts its removal with the magnet. When the foreign body is located in the anterior two-thirds of the vitreous, its removal is usually easy because it is possible to get a good exposure and an exploration of the area is not difficult.

Foreign Bodies Situated In The Posterior Third Of The Vitreous:—These foreign bodies are always difficult to remove, — because of their location, because of their small size, and because it is difficult to get adequate exposure to permit proper manipulation of the magnet. Therefore, I do not hesitate to incise the conjunctiva freely and disconnect one or more muscles so that the tip of the magnet can be applied at the point closest to the foreign body. Of all the problems encountered, this situation is the most difficult, and yet, it is so essential to get the magnet as close to the foreign body as possible.

The Technique For Removal will now be explained in detail:—A Van-Lint Akinesia and a retrobulbar injection of novocaine is given. I incise the conjunctiva freely, then detach the muscle or muscles from their insertions and expose the sclera widely. The practice of pulling muscles aside with a hook is not satisfactory and is to be condemned. Make an adequate meridional incision at least 5mm long through the sclera and retina. By working on a soft eyeball and by gently pressing the tip of the magnet at the opening, separates the sclera and makes a free path for the exit of the foreign body without losing vitreous. I do not insert the tip of the magnet into the vitreous, since this procedure is unnecessary. My experience has been that with an exact localization and a good working magnet if the foreign body does not appear with the magnet placed outside of the eyeball, it will be rarely obtained by inserting the tip of the magnet into the vitreous. It is desirable to make a clean incision through the sclera and retina to prevent the tearing of the tissues by the foreign body as it is drawn toward the magnet. It is not necessary to suture the sclera since it comes together neatly and heals rapidly. Diathermy or chemical cautery of the surrounding area are superfluous procedures.

Localization Methods:—Because of the various types of steel and steel alloys made today, a foreign body may vary in its magnetic quality. It may possess a high degree of magnetism, or, a low degree, and then it might not be magnetic at all. Because of this fact an exact localization of the foreign body to determine the precise spot on the eyeball through which to remove it is essential since an error of a couple of millimeters will determine the success or failure of the removal.

The Berman Locator:—What is the Berman Locator? Briexfly, the Berman Locator is a portable electro-magnetic device designed to help locate small magnetic particles situated inside an eyeball. The most important part of the locator is the probe. The technique for locating a small magnetic foreign body is simple. A good exposure of the eyeball is necessary. The tip of the sensitive probe is then passed slowly over the eyeball. The point on the surface where the needle reaches the highest reading on the scale indicates the spot closest to the location of the foreign body. However, one may have some difficulty with its use when a low magnetic foreign body is located deep in the vitreous or, when the foreign body is located in the posterior segment of the eyeball. This occurs because it is difficult to get adequate exposure of the posterior

part of the eye and this lack of exposure prevents thorough manipulation of the tip of the probe with the resulting readings becoming indefinite and confusing. When used well the Berman Locator can be almost self-sufficient in locating a magnetic foreign body within the eyeball especially when the foreign body is near the sclera or when it is in the most accessible parts of the eye.

The Sweet Method Of X-ray Localization:—Films are made of the eye containing the foreign body in accurate relationship to two fixed objects 10mm. from the cornea. The two fixed objects consist of a tiny ball and cone, each supported on a rod. The patient fixes his eyes on a distant object and a true lateral x-ray is taken. Leaving the ball and cone in position, the x-ray tube is shifted toward the patient's feet so that the image of the ball and cone are more widely separated and a second exposure is made. The localization is then figured out by the projection of the measurements and lines on a chart. This method is the most accurate and when a good technique has been once developed, it is almost infallible.

Foreign Bodies—Their Nature and Size:—The density of the shadow of the foreign body seen on an x-ray film is no criterion of its degree of magnetism or of its ease of removal. A tiny foreign body one-half by one-half millimeter in size will appear to be pin-point on the x-ray film. A steel foreign body this size located within an eyeball is best left alone because it is too small to damage the eye and because of the smallness of its size it may not be attracted by the magnet.

A magnetic foreign body larger than one-half by one-half millimeter in size should be removed since it is large enough to be grasped by the magnet and its presence inside the eyeball can do some damage by the chemical changes occurring between the steel and the intra-ocular fluids.

Non-magnetic foreign bodies such as brass, copper, glass, and so forth, located in the vitreous cannot be removed by the magnet. Fortunately their occurrence is extremely low in my experience, certainly less than one-half of one percent.

The Nature and the Use of the Magnet:—The strength of pull of the magnet is due to the number of the lines of force created. The number of the lines of force are directly proportional to the number of the turns or windings of the coil and the thickness of the core.

The Lancaster or the Sweet Magnet are the most practical and the only ones that are needed. The giant magnet is never used in our practice. The Olive or stubby tip is the most desirable when removing a foreign body from the vitreous. When recovering a visible foreign body from the anterior chamber, the thin tip is the most practical. The anterior chamber is the only place in an eye where the magnet can be inserted without doing harm.

Great caution should be exercised in manipulating the magnet because carelessness would cause dislodgment of the foreign body. Be sure that the electric current used is a direct current. The magnet will not function when attached to an alternating current. It is important to place the magnet in position so that the tip is at the mouth of the opening into the eyeball before turning on the current. By applying gentle pressure on the sclera the lips are kept apart and an easy exit is made for the foreign body. Occasionally it is necessary to turn off the current at one second intervals to loosen the foreign body. At the same time the tip of the magnet is moved in a small arc in order to change slightly the position of the lines of force and to make the pull of the magnet more effective.

Embedded Foreign Bodies in the Ciliary Body:—Fortunately their occurences is very small — less than one half of one percent. The use of the Berman Locator is ideal in this situation.

The Use of Atropine and Eserine:—Avoid the promiscuous use of atropine or eserine especially in ointment form because they are both strong drugs and their action is prolonged. Do not use atropine when their is much hemorrhage or when a secondary glaucoma might develop. Eserine stimulates hemorrhage and may cause pain from the spasm of the ciliary body.

STATISTICS:—In a series of 82 consecutive cases of intra-ocular foreign bodies covering a period of two years,

19.5% the foreign body was in the vitreous and all of the vision was recovered;

21.9% developed traumatic cataracts;

7.3% the eyeball was damaged beyond repair and had to be enucleated;

7.2% developed a retinal detachment after

removal of the foreign body;

4.8% the foreign body was retro-bulbar with a total loss of vision;

7.3% developed either siderosis or chalacosis with a total loss of vision.

7.2% the foreign body was in the anterior chamber and was removed by making an incision through the periphery of the cornea. An iridectomy was not done in any of these cases;

19.4% the foreign body was located in the inner third of the cornea and was removed under the slit-lamp;

4.8% the foreign body was lodged in the interior of the lens and in each case the foreign body was removed at the same time as the cataract.

All Foreign Bodies Should Be Removed If Possible regardless of their composition if you can get at them without causing damage to the eyeball. I never accept the patient's assertion that the materials upon which he was working at the time of the accident were not magnetic. Usually, he is apt to be misleading. The only time that one can be certain that the foreign body is not removable, is after repeated attempts have been made with the magnet and no foreign body is obtained. My experience has proven to me that many foreign bodies are extracted when the use of the magnet is attempted that otherwise would have been left to remain inside an eye.

CONCLUSION:—The most important facts to be considered in the removal of a foreign body from inside an eyeball are:

1—an exact localization of the foreign body by x-ray or Berman Locator or both

2—a good adequate exposure and

3—attempt removal always with the magnet.

DISCUSSION

Dr. Rampona — The time is short and I am unable to give the statistics. I wish to thank Dr. Allen for his discussion of this paper and Dr. Guibor in giving helpful suggestions when this paper was in process of being written.

Dr. Thomas D. Allen, Chicago: I especially like Dr. Rampona's insistence on exact localization and adequate exposure. I like the fact that he speaks of more than one x-ray. I remember one patient who was brought in with a blind eye. You could not see inside of it because of a cataract. We knew that he had had a perforation of the cornea, a perforation of the iris, and a perforation of the lens. We thought there must be something back in that eye. We had an x-ray and there was nothing found. Then we had Dr. Porter x-ray him and he found a 1.5 mm. piece of steel in the optic nerve head. I think you ought to have more than one x-ray taken and by different men.

I would like to take exception to one or two things. I presume he might take exception to one or two things I might say. He said it was unnecessary to insert the tip of the magnet into the vitreous chamber. I cannot forget one patient who had a fairly large foreign body in the eye, a patient of Dr. Wilder. We removed it with a magnet after x-ray. Then for some reason or other Dr. Wilder said, "let us take another x-ray". I think he suspected something wrong. The size of the foreign body was not quite like the size of the one shown in the x-ray. We had another x-ray. The foreign body was there where it had been at first. He went in a second time and really went into the vitreous chamber. He went in with a very thin tip. You can use the Lancaster hand magnet, or the larger (giant) magnet. I do not think we have used the great big giant magnet in years in the office, though we still use it at the hospital.

He spoke about cauterization near the edges of the wound as we do when shortening an eyeball for detachment of the retina. I think this is a good thing. You can incise the retina if you want to, but certainly if the retina is damaged you ought to cauterize all around the area. It helps seal off the operated area, and sometimes prevents detachment of the retina in our estimation.

I believe Dr. Rampona said tiny magnetic foreign bodies in the eye need not be removed. I do remember that a foreign body, ½ x ½ mm. went in through the eyelid and through the sclera of a son of one of our professors at Rush College. The father was chopping wood. A little piece flew off, penetrating the eyelid. That was all the attention that was paid to it until six weeks later, when the boy began to have an iridocyclitis. Then we x-rayed him and found a very tiny foreign body, ½ x ½ mm. in the vitreous; but it was too late to save the eye.

To mention one other point about the anterior chamber, it is said that is the only part of the eye where the insertion of a magnetic tip can be done without damage. I think it is always dangerous to insert anything into the eye. I think one ought to be extremely careful. I remember one cataract case, in which we used a new knife I had brought from London. The knife penetrated the limbus, but Dr. Wilder could not make the counter puncture. On withdrawing the knife we found the end had broken off. It was imbedded in the opposite limbus, and it was one awful job to remove it, even with the magnet. Fortunately we did not get a postoperative complication.

The Physiology of Abdominal Pain

Morton I. Grossman, M.D.
Professor of Clinical Science (on leave of absence). From the U.S. Army Medical Nutrition Laboratory, Chicago, Illinois, an installation under the jurisdiction of the Surgeon General.

SEMINAR
of the
DEPARTMENT OF MEDICINE
UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE

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A discussion of abdominal pain should begin with a few words concerning the physiological anatomy of pain conduction. The pain receptors in the gastrointestinal tract, as elsewhere, are undifferentiated nerve endings. They transmit impulses via the splanchic and pelvic nerves, without synapses in the sympathetic ganglia, to the dorsal root ganglia. They synapse in the dorsal gray matter, cross and ascend in the lateral spino-thalamic tract to the thalamus and the post-central gyrus of the cortex and the frontal cortex. The vagus nerve, of course, contains no pain fibers. Accordingly, pain can be interrupted by peripheral section, by section of the spino-thalamic tract, by topectomy and by lobotomy.

The most common stimulus of pain fibers is injury to tissue. It has been postulated by Sir Thomas Lewis that injury releases a neurohumoral agent, the P. substance, which has not been adequately identified. In fact, Dr. Sol Roy Rosenthal feels that the P substance is histamine. Unlike most nerve endings, pain fibers show little, if any, adaptation to repetitive discharge. The intensity of pain stimulus depends on the frequency of impulses and the number of pain fibers which are involved.

Several theories have been advanced to explain gastrointestinal pains. One group of investigators holds that the gastrointestinal tract does not contain pain fibers; that abdominal pain is always pain of the mesentery. I do not personally share this concept. It is my feeling that pain fibers, though sparse, are present in the gastrointestinal tract but that special stimuli are needed to fire them in an uninflamed bowel. Inflammation greatly increases the sensitivity of pain receptors; and, while only contraction and distention are known to produce pain in normal bowels, in the presence of inflammation many lesser stimuli will become painful.

One must distinguish five types of pain in visceral disease. The first type is true visceral pain which is referred to the site of pain stimulation itself.

The second type is referred pain which, though arising from an abnormality of the viscus, is referred to a somatic area. The somatic site of reference is supplied by the same spinal segment as the damaged viscus. The area of reference is deeper than the skin. While many theories have been proposed for its explanation, the final nature of its pathways has yet to be established. Some authors believe that visceral and somatic pain fibers converge in the second neuron; Head's law, on the other hand, suggests that the transformation of pain from visceral to somatic areas occurs in the cerebral cortex; and others believe in the existence of axone branching, which would connect axones of somatic directly with those of visceral areas.

The third type of gastrointestinal pain is non-referred somatic pain associated with visceral disease as in extension of a disease process to the perietal peritoneum. The fourth type is secondary referred visceral pain. An example

The opinions expressed in this paper are those of the author and do not necessarily represent the official views of any governmental agency.

of the fourth type is the pain in appendicitis, which is referred to the epigastrium secondarily as a result of the pylorospasm arising from the viscero-visceral reflex between appendix and pylorus.

The last, fifth, type of gastrointestinal pain is of particular importance from the clinician's point of view. It is the habit reference pain of patients who refer pain to areas which have become sensitized because of prolonged disease. Patients suffering from chronic gall bladder disease, for instance, might refer "coronary pain" to the right upper quadrant, a fairly common and often misleading clinical finding. As a whole, pain is always referred from deep to superficial structures, probably because of an increasing level of sensitivity to pain towards the surface. One might mention here that some references are bizarre and poorly understood as yet. We do not know, for instance, why patients experience pain in the jaw subsequent to myocardial infarction.

Pain which originates from visceral disease is often accompanied by pilomotor, vasomotor and somatic phenomena in the area of reference. Sweating may occur; Lewis' triple response may be accentuated; and spasm of skeletal muscle, accompanied by tenderness and hyperalgesia might develop. It might be worthwhile to enumerate briefly the sites of reference for abdominal pain. The eosophagus is inervated by the first to the seventh thoracic nerves; pain underlies the sternum, and the level of reference corresponds, in general, to the level of the pathological change.

The stomach is supplied by the seventh to the tenth thoracic nerves; pain is referred to the epigastrium usually just to the left of the mid-line. Pain from the duodenum (which is inervated by the ninth and tenth thoracic nerves) resembles referred gastric pain but tends to localize just to the right of the mid-line. Pain from the small intestine is felt in the periumbilical area, from the terminal ileum segment and appendix in the right lower quadrant. Pain from the colon might be referred to any part of the abdomen: changes in the fixed areas of the large bowel are usually felt in the overlying parts, while involvement of the free portion is referred in general to the hypogastrium, just suprapubically.

The pancreas is inervated by the seventh to the eleventh thoracic nerves, the biliary tract by the seventh to the ninth: the biliary tract, as a rule, shows a well defined lateralization of referred pain. The kidney, ureter (and, by the way, part of the colon) have unilateral inervation which facilitates the clinical identification of pain originating from these structures.

DISCUSSION

Dr. Gilbert Kipnis, Clinical Assistant in Medicine: You have discussed reference of pain to overlying areas and lateralization of pain. How do you explain the back pain in pancreatic disease?

Dr. Grossman: The exact mechanism of pain referred to the back is not known. It occurs not only in pancreatic involvement but also in other types of abdominal disease. I am tempted to say that it is more common in pancreatic involvement because of its retro-peritoneal location.

Dr. Angelo Creticos, Clinical Instructor in Medicine: Is it the pancreas or the pancreatic capsule which contains pain fibers?

Dr. Grossman: The pancreas proper, presumably. In recent studies, minute electrodes have been implanted in the pancreatic tissue and definite pain has been produced by electrical stimulation.

Dr. William Mandel, Instructor in Medicine: In this respect, the liver . . . (Dr. Samter, interrupting) and the lung, Dr. Mandel . . . differs, I believe, from the pancreas?

Dr. Grossman: Yes. This is correct. The pain fibers of the liver appear to be located in the capsule. Similarly, pneumonia is usually painless, while both bronchitis and pleurisy are painful because bronchi and pleura contain pain fibers, while the parenchymal tissue of the lung does not.

A Physician: Do you find that the spleen contains pain fibers?

Dr. Grossman: As you know, the spleen, as a rule is not sensitive to pain. If inflamed, however, it becomes painful: as a rule pain is referred to the overlying areas, but there can also be diaphragmatic reference on occasion. Pain from the central region of the diaphragm, by the way, is referred to the tip of the shoulder.

Dr. Louis Johnston, Research Assistant in Medicine: What is your explanation of the shoulder-hand syndrome?

Dr. Grossman: I believe that the shoulder-

hand syndrome results from viscero-somatic reflexes which eventually produces a dysfunction of the involved parts.

Dr. Melvin M. Chertack, Clinical Instructor in Medicine: It seems to be accepted that injection of local anesthetics into areas of referred pain is of little therapeutic value. Yet, if referred pain were caused by axone branching, local anesthetics should have at least some effect.

Dr. Grossman: I am not certain that this is correct: even if one would accept the concept of axone branching as an explanation of referred pain, you would still deal with both pain of central as well as peripheral origin. Clinically, one might state that local anesthetics will relieve areas of referred pain only if the pain has been complicated by local changes, for instance, spasm of peripheral muscles.

Dr. James Schoenberger, Assistant Professor of Medicine: What is your explanation of deep bone pain?

Dr. Grossman: Bone marrow has no pain fibers. Deep bone pain must be a deep somatic pain referred from the cortex of the bone.

Dr. Chertack: Would you care to comment on the nature of biliary dyskinesia?

Dr. Grossman: I believe that the term 'biliary dyskinesia' needs some clarification. If you mean pains which occur after removal of the gall bladder, they are usually due to a spasm of the sphincture of Oddi. If you feel, on the other hand, that biliary dyskinesia is a disease entity you will find disagreement among gastroenterologists as to the existence of such a syndrome.

Dr. Johnston: Are ulcer pains caused by hyperacidity or by pyloric contraction?

Dr. Grossman: Normal subjects can tolerate infusion of hydrochloric acid into the stomach without pain. In patients suffering from ulcers the acid undoubtedly acts as a chemical irritant to an inflamed area. Acid is the primary pain stimulus for ulcer pain. Motility may contribute in some cases as a pain stimulus.

Dr. Buford Hall, Senior Resident in Medicine: What is the mechanism of ischemic pain?

Dr. Grossman: Anoxia of active muscle tissue which produces chemical substances which excite pain endings. Pain from coronary ischemia is, of course, the foremost example of this particular type of pain.

Dr. Robert Kaiser, Clinical Assistant in Medicine: If histamine is the P substance, why do antihistamine drugs fail to control pain?

Dr. Grossman: I would guess that they lack the required specificity for this particular receptor.

Dr. Mandel: How does ACTH happen to control pain?

Dr. Grossman: ACTH, like aspirin, probably does not act on pain fibers but reduces pain by reducing the inflammatory process; neither increases pain threshold.

Dr. John Louis, Clinical Assistant in Medicine: Would you add one final word about the significance of the history of pain in the individual patient?

Dr. Grossman: I can sum up my answer in one sentence. I believe that a case history of pain in gastrointestinal disease is one of the most important, perhaps I should say the most important, diagnostic tool.

It's NOT Too Early

to plan for your Annual Meeting,

Chicago, May 19, 20, 21, 22

CASE REPORTS



Infectious Mononucleosis Complicated by Encephalitis With Permanent Damage to the Central Nervous System

Salvatore A. Motto, M.D.
Chicago

Within the last 15 years the protean nature of infectious mononucleosis has been emphasized repeatedly in the literature by observing authors [1,2,3,4,5,6,7,13,14,15,17]. The neurological signs and symptoms of this clinical entity occasion grave concern to the attending physician until the diagnosis is established. Then, because of the reported benign character of infectious mononucleosis, his anxiety lessens and he reassures the patient and family of the usual complete recovery from this disease.

Infectious mononucleosis with a complicating involvement of the central nervous system has been recorded by numerous authors[8,9,10,11,12,16,18,19,20,21,22] but little or no emphasis has been placed on the possibility of some residual pathology. Several reports, however, have sounded an ominous note in warning that this disease may leave its mark for a longer time than previously suspected. W. W. Dalton[17] mentions a young girl who, within six weeks of apparent recovery from the disease, presented signs and symptoms of myocardial insufficiency in a previously accepted normal heart. A. Bernstein[24] discusses a patient whose spleen descended 8 cm. below the costal margin during the acute illness; seven years later she still presented a palpably enlarged spleen. T. C. Bernstein and H. G. Wolff[19] in their review, cite three cases of complicating neuropathy in which the affected muscles apparently were accepted as permanently paralyzed and one case of encephalitis with permanent im-

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pairment of mental concentration and mild aphasia of the motor type.

The case report presented emphasizes the fact that infectious mononucleosis is not necessarily just a nuisance disease with only transient observable effects but is in reality a formidable disease that may produce alarming signs and symptoms and leave permanent damage. The case proved to be of interest to the staff of St. Mary of Nazareth Hospital in view of the history and physical findings presented to the several general practitioners, neurosurgical consultant, chief surgical consultant, and internist who examined her at different intervals over a three week period before the diagnosis of infectious mononucleosis was established. The laboratory data and subsequent course of the disease served to substantiate the diagnosis of infectious mononucleosis with a complicating encephalitis that left the patient with a lasting, elicited, horizontal nystagmus and right facial paralysis.

D. L., a 20 year old white female entered St. Mary of Nazareth Hospital, Chicago, because of fever, sore throat, numbness in the right side of the face a sensation of "pins and needles" in left hand and foot, and progressive lethargy. There was a three week history of "head cold" and mental depression and the patient had been seen by two general practitioners who prescribed medication for the suspected upper respiratory infection and mental depression assumed to have been precipitated by the departure of the patient's fiance for the army. The prescribed therapy gave no relief. The patient was a dental technician and her past history revealed measles and chickenpox during infancy, and appendectomy at 8 years of age, and a tonsillectomy at 10.

Emergency medical consultation on the day of admission was requested by the attending physician and rendered by the author. Examination revealed a well nourished, well hydrated white female who was lethargic and flushed with fever. The blood pressure was 120/80 with a regular, good pulse of 110. The temperature was 100 degrees F. rectally and the respirations were 20. There was a spontaneous, horizontal, nystagmus with quick movement to the left. The right nasolabial fold was erased in an obvious paralysis. The fundi were normal; the eardrums were intact, and each had a normal light reflex; the thyroid was not palpably enlarged. No nuchal rigidity was present but the neck had a symmetrical fullness throughout and presented palpably enlarged bilateral anterior cervical lymph nodal chain; the posterior chain was only slightly palpable. The patient had difficulty in speaking and seemed to have considerable dysphagia. Examination of the oropharynx revealed severe hyperemia and much tenacious phlegm. The palatine tonsils were absent. The lungs were normal but the heart presented a soft systolic murmur at the apex that was not transmitted elsewhere; tachycardia of 110 regular full beats was present. The abdomen was slightly distended with gas but no tenderness was noted. The liver, kidneys, and spleen were not enlarged to palpation. No masses were discovered and the bowel sounds were normal. The genitourinary system, anus, rectum, bones, and joints did not show any gross evidence of disease. The muscular system revealed no swellings, atrophy, fibrillations, tenderness, or weakness. The reflexes were physiologically brisk; no pathogenic reflexes were elicited and no reflexes were absent. The Romberg sign was negative. The patient was unable to hold up her head without dizziness and she was afraid to stand up and walk because she felt she would fall. Touch and pain sensations were intact as shown by cotton touch and pinpoint discrimination. Further studies were indicated to determine the etiology of fever. Seven major clinical conditions were considered: encephalitis complicating virus systemic disease; poliomyelitis, bulbar type; Guillian-Barre syndrome; infectious mononucleosis with encephalitis; diphtheria; acute leukemia with cerebral hemorrhage; and cerebral tuberculoma.

On the day following admission the consulting neurosurgeon, Dr. J. P. Cascino regarded the presenting clinical picture as limited to a consideration of: encephalitis of unknown viral etiology; Guillian-Barre syndrome and infectious mononucleosis with encephalitis. The chief of staff, Dr. E. Warszewski, who was the attending physician, performed a lumbar puncture which revealed crystal clear fluid under a pressure equivalent to 180 mm. of water with normal dynamics. It contained 10 polymorphonuclear cells per cm. The Pandy test was slightly positive; the sugar, 57 mgm.; the total protein, 64 mgm.; and the chloride, as sodium chloride, 600 mgm. per 100 cc. The specimen yielded no

growth on culture.

The bone marrow aspiration performed on the second day of admission revealed heterogenous moderate cellularity with essentially normal megakaryocytes. The RBC:WBC ratio equalled 1:10. Erythropoieses was normoblastic and granulopoeises was accelerated with a shift to the left. There was a marked increase in monocytoid cells and a moderate increase in plasma cells. The conclusion reached was that of no diagnostic bone marrow pattern but the findings were compatible with infection.

Nasopharyngeal and oropharyngeal direct smears and cultures revealed no diphtheritic organisms but beta-hemolytic streptococcus and staphylococcus aureus were present. X-rays of the chest and skull were essentially negative. Urinalysis was negative and subsequent culture revealed no growth. During the first three hospital days the patient persisted with a 101 F. rectal temperature which receded to 100 degrees F. in the next five hospital days and then returned to normal and remained normal until her discharge from the hospital three weeks from the day of admission.

Initial examination of the peripheral blood disclosed a red cell count of 4,100,000 with a hemoglobin of 12.0 gms. per 100 cc.; and a white cell count of 16,800 with 17 per cent segmented neutrophils, 10 per cent stab neutrophils, 1 per cent eosinophils, 70 per cent lymphocytes, and 2 per cent monocytes. Five per cent of the lymphocytes were considered prolymphocytes and less than 2 per cent were so immature they were difficult to differentiate from lymphoblasts. At least 10 per cent of the lymphocytes had fenestration and heavy nuclear, chromatic network. The Kahn serological examination was negative. On the third hospital day the heterophile antibody titer was 1:128; on the sixth hospital day, 1:64. It returned to normal of 1:32 on the 15th hospital day. The patient's WBC fell from the initial 16,800 to 9,500 within 48 hours after admission and fluctuated between 6,500 and 9,500 during the remainder of her hospital stay. The lymphocytosis, however, changed from the initial 70 to 81 per cent 48 hours after admission with typical Downey cells as described above and fluctuated between 48 and 81 per cent during the first two weeks of hospitalization. The complete blood count on discharge was RBC 3,940,000; hemoglobin, 12.5 gms. per 100 cc.; and WBC, 6,500 with 54 per cent segmented neutrophils, 3 per cent stab neutrophils, 42 per cent lymphocytes, and 1 per cent monocytes. No abnormalities in morphology were seen at this time. Repeated blood examinations which showed lymphocytosis and fenestrated lymphocytes, abnormal heterophil-antibody titer, absence of significant anemia, and the nonspecific bone marrow study substantiated the diagnosis of infectious mononucleosis.

The patient's spleen was at no time palpably enlarged. Her postural dizziness began to recede seven days after admission and she was then able to sit on the edge of the bed without discomfort. During the next two weeks she managed to get up and walk but maintained her equilibrium with difficulty. Her gait was cautious as if she were afraid she might fall. No abnormal objective neurological findings could be detected on daily examinations to account for this patient's parasthesia in left arm and leg. Her right facial paralysis showed little sign of improvement during her hospitalization even though she was given galvanic physiotherapy treatments for two weeks. The right eye developed the usual conjunctivitis following absence of palpebral movement but this responded to ophthalmic ointments and daily irrigations with isotonic solutions. The only other medication consisted of 600,000 units of penicillin and 1 gram of dihydrostreptomycin daily and large doses of vitamin B complex orally.

After the patient's discharge she was examined bi-monthly for the following three months and then monthly for nine months. The spontaneous, horizontal nystagmus receded to an elicited, horizontal nystagmus two weeks after discharge from the hospital and has persisted up to the present time. The right facial paralysis responded slowly to galvanic and massage therapy administered three times weekly over a period of three months. The physio-therapist then believed that the patient had received maximum benefit from galvanic therapy and instructed her to continue with daily facial massage only. After 12 months of diligent effort, the forehead wrinkle returned along with increased strength in her right palpebral movement. The weakness in the right nasolabial fold has persisted. For two months after discharge from the hospital the patient retained a cautious gait due to a feeling of insecurity when standing;

she felt as if she were learning to walk all over again.

SUMMARY

A case of infectious mononucleosis with encephalitis is presented in which the patient has permanent central nervous system damage as manifested by a persistent, elicited, horizontal nystagmus and residues of right facial paralysis 12 months after onset of the disease. It is hoped that infectious mononucleosis will be considered a formidable disease and not dismissed casually as a nuisance, technician's, or medical student's disease with only transient effects.

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DATA ON PHYSICIANS

There were 211,680 physicians in continental United States at the end of 1951, according to the annual licensure report, prepared by the AMA's Council on Medical Education and Hospitals. During the year, 6,282 persons obtained licenses for the first time. The net gain of 2,640 results from subtracting the estimated number of deaths from the 6,282 newly licensed physicians. In order, the following five states had the greatest number of first time licentiates: New York, 743; California, 526; Illinois, 437; Ohio, 394; and Pennsylvania, 388.

A total of 12,008 licenses were issued in the United States and possessions last year by examination or by endorsement of credentials. This total includes previously licensed physicians who moved to other states. During 1951, the nation's 72 approved four year medical schools graduated 5,018 new doctors who later took license examinations. Of these, 4,874 (97.1 per cent) passed. In comparison, only 842 (57.9 per cent) of the 1,455 graduates of other schools passed state board examinations. Altogether, 6,473 persons took state boards. Of these, 5,716 (88.3 per cent) passed. The National Board of Medical Examiners, whose certificate is recognized by all states except Florida and Texas, examined 7,738 candidates, of whom 97.7 per cent passed. The high passing rate is explained by the fact that the Board did not examine graduates of unapproved medical schools, extinct approved schools, or schools of osteopathy. It examined only 12 foreign graduates. *J. Student A.M.A. Oct. 1952.*

COUNCIL MEETING MINUTES

MINUTES OF COUNCIL MEETING,
DECEMBER 14, 1952

A regular meeting of the Council of the Illinois State Medical Society was held at Hotel Sherman, Chicago on Sunday, December 14, 1952, with the following present: Sweeney, Stone, Lewis, Kirby, Muller, Lundholm, O'Neill, Oldfield, Vaughn, Reichert, Blair, Reisch, Newcomb, Montgomery, Fullerton, Hamilton, White, Hopkins, Hutton, Coleman, Cross, Goodyear, Hayes, Bornemeier, Hoeltgen, Limarzi, Hirsch, Hedge, Mr. Ralph Carpenter, Leary, Neal, Camp and Frances Zimmer. Minutes of last meeting were approved.

Secretary had mailed his regular report before the meeting, and gave a supplementary report with financial report of the Treasurer. Letter from Governor Stevenson in reply to letter sent following last meeting telling the Governor the fine work Roland Cross had done as Director, State Department of Public Health. The Governor stated that he was aware of the work of Cross and improvements in the health of the Illinois people. Thanked the Society for the fine cooperation given to Cross and his Department. Secretary gave a report of the work done from his office of the Physician Placement Service. This function carried on through his office since the Warmanpower Commission Procurement and Assignment Service for Physicians ended one year after the end of World War II. Some 70 physicians aided in finding suitable rural locations, giving details of plan now in operation to investigate both the physicians desiring a location, and the community and what it has to offer. The rather lengthy report was ordered mimeographed and a copy sent to members with the minutes of this meeting. Secretary gave a brief report of actions taken by the A. M. A. House of Delegates at the December Interim Session held in Denver. Some resolutions referred to, with recommendations of the reference committees, and final action taken by the House. Among these the problem of fee splitting, and that of Branch Practice. Judicial Council had ruled that physicians located some distance from a clinic, sending patients there for care, and receiving a percentage of fees collected, was unethical practice on the part of the clinic as well as the referring physician. Judicial Council failed to give a legal definition of fee splitting, and ruling as to what types of fee division when two or more physicians were jointly participants in giving care to patients, were ethical and what types are unethical. Letter from Councilor Greening was read, he being in Arizona, office in Chicago had been closed. Greening said he would leave it to the judgment of the Council as to whether a resignation should be accepted and a replacement made for the remainder of his term. Secretary said this should be left to the judgment of the Chicago-Cook County members of the Council.

SWEENEY reported as president, telling of his recent assignments, meetings attended and various things which had been referred to him, as president of the Society. Told of some appointments he had made recently as requested by the A. M. A. and other organizations.

LEWIS, as president-elect, has attended a number of meetings, including the one at Pinckneyville honoring James S. Templeton, who was selected as the outstanding general practitioner of Illinois during October. He told of some assignments given to him at the A. M. A. session in Denver, he still being in the Illinois delegation.

STONE reported as Chairman of the Council, telling of his many meetings recently attended, and some functions he had had delegated to him. Was present at the meeting at Pinckneyville, honoring Templeton on No-

vember 18. He also attended the P. G. Conference at Joliet December 10, excellent program, but rather poor attendance, especially for the evening session. Individual Councilors were called upon for their reports between reports of committees. O'Neill referred to a physician in his district, not yet a citizen, but the county society had erroneously accepted him for membership. This is contrary to the By-laws, and should the local society refuse to accept dues for the next year? It was decided that the Secretary should notify all component society secretaries of this By-law, and insist that dues not be accepted for 1953 from any other than American citizens. O'Neill referred to a project under consideration; a hospital was considering taking small chest film for all patients admitted; the T. B. Chapter would pay expense up to $4000.00 and the hospital was asked to assume the rest of the cost. Would like the opinion of Roland R. Cross, as to whether or not this should be done. Cross stated that all work which would aid in the early detection of tuberculosis should be encouraged and that a program of education should be developed in all Illinois counties. BLAIR told of the recent post graduate conference held in Peoria which was well attended and of the outstanding program. Also told Council that incoming Governor Stratton had appointed Judge Vera Binks of Kewanee to head the State Department of Registration and Education.

BLAIR reported as Chairman of the Educational Committee, telling of the recent meeting held over the facilities of the Bell Telephone System, this at 10:30 P. M., November 11, the conference lasting 15 minutes with all members on the line, and at a total cost of $22.40. Referred to renewal of the "TV" Health shows, which had been off the air for nearly six months. Referred to possibility that the show would need a sponsor, to continue its operation at a decent time. This would entail some new problems which would need to be approved by the Council before being placed in operation. Blair referred to other functions in the Educational Committee office.

HOPKINS reported as Chairman of the Committee on Medical Service and Public Relations telling of meeting of the committee the previous day and some of the current problems which were discussed. Called on Leary to continue the report, on public relations activities, LEARY plans to continue the field work as started last year; he will again go into counties to meet officers and key men of component societies to tell what the Society is doing along these lines, get their suggestions, and bring them back to the committee as a whole. Leary asked for Council support, and would like their suggestions, as to how these small conferences may be improved. Told of his work in preparing material to be submitted to the A. M. A. Board of Trustees, in presenting James S. Templeton as this society's candidate for outstanding practitioner of the nation. Referred also to Templeton appearing on "This is Your Life" TV show presented from Hollywood. Told of meetings of the Interprofessional Council and the need for better representation from this Society at these conferences. Currently Hedge, Stone, Neal, Leary attending them along with the chairman, Wayne Slaughter.

LEARY presented report for Post Graduate Education Committee in absence of the chairman, George Hellmuth. Meetings have been held so far in Chester, Peoria and Joliet. Does not seem possible at this time that the complete series as tentatively outlined can be presented. To do so would necessitate scheduling many conferences during mid-winter and this might prove unsuccessful with a number during the winter season. Meetings have been well attended, and programs excellent. Medical schools and hospitals have been cooperating well indeed. Urged individual councilors to do their part in recommending time, and type of programs desired for the places tentatively scheduled to date. HAMILTON referred to one recently held in his district with fairly decent afternoon attendance, but very few remaining for the dinner and after-dinner presentations. There were some conflicts, local men not remaining for evening session. Wonders if it might not be desirable to end the P. G. conference at 5:30 or 6:00 P. M., having no dinner or evening session. Also suggests possibility of having fewer speakers and longer presentations, and give the host society and others in the area the opportunity of making their own recommendations as to subjects, speakers, etc. Further discussion by White, Camp, Fullerton, and Blair. Limarzi discusses the subject of post graduate conferences, suggesting that a survey be made at the local level to see what the members actually want. He believes 20 minute papers are sufficient, and this shorter time tends to hold the speaker to his subject, than a longer one. Reisch stated that the local survey has been made in Sangamon County and they know the type of program they want presented. Suggests that the talks and program material in general be varied, to appeal to all types of practitioners who will attend. They propose to have a different type of program when the conference is presented in Springfield during April. NEAL tells of Superior Court of Cook County upholding the decision of the Department of Registration and Education two years ago, in refusing approval to the Chicago Osteopathic School as a medical school whose students could take the unlimited license examinations. Some other decisions and actions were reported by Neal. Likewise Neal referred to the opening of the Illinois Legislative Session the first of January and some matters pertaining to health, which may be presented.

LIMARZI reports as Chairman of the Scientific Service Committee, telling of recent activities, speakers for many county society meetings arranged. One society recently came to the Chicago office of the Society, and while there arranged a full schedule of meetings for the year 1953, for his Society. A sub-committee has been working on the proposed new list of speakers — subjects, and some of their recommendations were presented to the Council by Limarzi. It is believed that when finally prepared, the booklet should be good for five years, with perhaps a supplementary sheet added annually to keep it up to date.

HIRSCH told of the activities of his committee de-

sirous of recommending changes in the present Illinois Coroners Act. Efforts underway to get the cooperation of the Illinois Bar Association. His report one of progress, and he hopes to have more definite information to present at an early meeting of the Council.

HUTTON told of meetings of a small group from the larger Committee on Medical History and he believes it is about time to consider the hiring of the individual to write the proposed book. Some debate as to whether a lay or a professional writer should be selected. Proposed chapters have been written by specialists in various branches of medicine, and the material must be looked over carefully, eliminating "overlapping", and getting the information better organized. Some correspondence with publishing companies, and committee expects to have more figures available to present at an early Council meeting. Report is one of progress, but Hutton believes it will soon be time to make final arrangements to actually produce a book. HUTTON also tells of the work of the Committee on the Eradication of Tuberculosis, which has been operating some eight or nine years. Believes that the point has been reached that the time and efforts of the Society will be lessened. Perhaps some recommendations will be made for changes in the tuberculosis laws in Illinois at the coming legislative session. Told of the Chicago Medical Society requesting a public health survey of the facilities for tuberculosis cases in Cook County. Believes it would be well to ask Cross to discuss the proposal. CROSS stated that he has received the request that he ask the Public Health Service to make the survey, but before this is done he would like to have the approval of the M. T. S., which he was told would probably be forthcoming soon.

MOTION: (Hamilton-Lundholm) that the Council request Dr. Cross to make an effort to obtain the necessary information as necessary to authorize the proposed survey. Motion carried. HUTTON reported as Chairman of the Editorial Board which last met October 21. Color for Journal again discussed, and it was agreed that beginning with the January issue, a red cover would be used for one year. Still considering the inclusion of some type of drug column to give information on newer drugs, and their uses. Big problem is that of source material. Several suggestions considered, but so far not definitely approved. Committee hopes to have definite plan to put into operation. Discussed further development of News of the State, and suggested that Woman's Auxiliary may be asked to aid in procuring more local news in all parts of the state. Committee on Medical Economics now endeavoring to develop more interesting articles for their section in the Illinois Medical Journal. The secretary has been asked to consider developing a new section "Know Your Society" in which the members would get general information on the various committees and their work. This should be of value to many members and will no doubt be undertaken in the near future. The Journal now being mailed from Mendota, where the printing is done, instead of from Oak Park. Journal advertising rates have been increased between 15 and 20% after January 1, or at expiration of existing contracts.

OLDFIELD discussed the inability of Greening to attend Council meetings. Stated the C. M. S. members have met, and believe it advisable to accept the resignation of Dr. Greening, and permit full membership representation from the C. M. S. Motion: (Oldfield-Vaughn) that it would be wise to accept the resignation of Dr. Greening, and Secretary be instructed to write letter to him explaining that no vacancy can be left for a year and a precedent be set in this manner. Motion carried. Oldfield stated that the C. M. S. members of the Council would like to recommend George Hellmuth to fill the unexpired term of Dr. Greening. Motion: (Blair-Reisch) that the Council accept the recommendation of the Chicago members and approve Dr. Hellmuth as the replacement for the unexpired term (to May, 1953). Motion carried.

COLEMAN referred to a meeting of the Medical Advisory Committee to the I. P. A. C. held the previous evening, December 13, at which many important subjects were considered. County medical advisory committee members are invited to sit in at each meeting to give them a first hand view of the many problems the committee considers. The Commission is worrying about the increasing costs for drugs in the program. The surplus as provided through the budget for its operation, has gone down rapidly during the past three months. A resolution was introduced by a member and approved by Mr. Keaster, whereby physicians be permitted to add $1.00 for dispensed drugs and list, but not itemize the drugs. Some physicians apparently are seeing chronic cases too often, which adds materially to the cost of medical care. Some problems in radiology had arisen, and will be brought in detail before the committee, perhaps at its next meeting.

REISCH reported as Councilor for the 5th District; the big problem before the Sangamon County Society is that of Branch Practice. The Springfield Clinic had representatives appearing before the Judicial Council of the A. M. A. at the Denver Interim Session the first of December. Sangamon County was represented by one of its officers. Apparently by going directly to the Judicial Council, the Clinic had by-passed the county and state societies. Efforts have been made at the local level to get a complete discussion of branch-practice, and the operation of the clinic involved. On December 9 the Board of Directors of the Sangamon Society, at a special meeting, heard the report of the group at which time they presented a printed presentation of some 67 pages. Later the medical society voted on the branch practice plan and the vote was that the Sangamon County Medical Society considered the branch practice of medicine unethical, based upon the Principles of Medical Ethics of the American Medical Association. The Clinic would like to present its case to the Council of the Illinois State Medical Society. Motion: (Lundholm-Fullerton) that each county medical society in Illinois be given the findings of the Judicial Council relative to branch practice. Motion carried. By proper motion, (Hamilton-Oldfield) the

Sangamon County society was to have its attention called to Chapter XII of the By-laws on Discipline, of the Illinois State Medical Society. Chairman Stone asked Reisch to procure additional copies of the mimeographed material prepared for the members of the Sangamon County Society, to be sent to each member of the Council.

By proper action, (White-Fullerton) John W. Neal was retained as General Counsel for the State Medical Society for 1953.

NEWCOMB, as councilor for the 6th district, stated that the Morgan County Society would like to have 1953 annual dues remitted for a member, a polio victim, who is practicing a little medicine from a wheel chair. The county society has recinded his dues, and requests that the State Society and A. M. A. do likewise. By proper action, (Newcomb-Oldfield) that this be done, and the Secretary's request be referred to the A. M. A. Motion carried. Two men had been elected to membership in Morgan County who had not acquired citizenship. This was contrary to the State Society By-laws and they have been so notified. Wonders what may be done to permit them to retain hospital staff appointments.

NEWCOMB told of a recent meeting of the Committee on Cardiovascular Disease, with representatives of the State Department of Public Health and Chicago Department of Health present. Three diagnostic clinics had been established in Springfield, Herrin and Chicago. Patients are invariably referred to their family physicians. Reference was made to the Heart Bulletin, published every three months. Efforts will be made to get funds to make this Bulletin available in downstate areas. The State Health Department and Chicago Health Department would like to send representatives to the meetings of the Heart Committee, to aid in developing a well worthwhile program.

GOODYEAR stated that on November 4, Election Day, about 85% of physicians' offices in Macon County were closed. He stated that Branch Practice problems are not confined to one area in the state, and this information, as that pertaining to fee splitting should go to every component society in the state.

CROSS reported as Director, Illinois Department of Public Health; thanked the Council for its expressions relative to his work as Director, and its desire to see him retained in that capacity. Tells of his great appreciation of the fine cooperation that has existed between the Department, the State Society and physicians of Illinois in general. Hopes this may be indefinitely retained. Discusses in detail, work done by a Team on Infectious Diarrhea of the Newborn, and by the Mobile X-ray units in the tuberculosis case-finding program. (These to be attached to the minutes of this meeting.) Cross told of a recent meeting he attended in Washington relative to the Doctor Draft Law. Seems quite likely that some changes will be made in the procedure in the near future. The use of Gamma Globulin in the prevention of paralysis in poliomyelitis was also discussed. The American Red Cross has agreed to make blood available for this purpose. Some 1,600,000 units have been used. The material will be distributed through the state on a limited basis, and epidemic areas will be cared for. Forms are prepared to be filled out by physicians using it, in order to cooperate properly in the program. The amount of rabies vaccine used in Illinois has increased alarmingly. There is a definite danger in its use, and it should not be given unless absolutely necessary. Extreme care should be taken and the public should be informed of the correct course to follow. Cross urged that a suitable editorial should appear in the Illinois Medical Journal on this subject. REICHERT stated that at Children's Memorial Hospital they have had two fatalities and eight cases of permanent paralysis from rabies vaccine. Symptoms of paralysis should be checked at all times; they usually appear after the 9,10,11th injection. The best procedure is to inform the family of all aspects of the use of the serum and let them aid in making the decision. Editorials will be prepared for publication in the Journal and appear in an early issue.

HEDGE reported as Chairman of the Grievance Committee, stating that the complaints are now being investigated, and a report will be given at the next meeting.

MULLER, as General Chairman, Committee on Arrangements for the 1953 meeting, stated that committees are being selected, and some members will be from societies in counties near Cook County in addition to the C. M. S. membership. The Woman's Auxiliary will have their supper party on Tuesday evening, as previously suggested.

HOELTGEN gave his report as Chairman of the Committee on Nursing; this a report of progress necessitating no action at this time. His report was attached to the minutes of the Council meeting. In the discussions following Hoeltgen's report, the matter of accreditation of hospitals having training schools, was given much consideration. The problem of reciprocity for the nurses who receive training in unapproved hospitals makes the situation quite serious. The question as to whether it might be advisable to have this accreditation left to the State Department of Registration and Education was discussed.

HAYES gave the report of the Medical Benevolence Committee, telling of the balance in the fund, and the expenditures. The present number of recipients, 33, changing from month to month. Monthly benevolence checks total from $1,350.00 to $1,500.00 per month. Approximately 80% of the beneficiaries are widows of former members. One case of an elderly physician hospitalized, and needing more assistance was discussed, without giving the name of this man. By proper action the Council voted to permit the Committee to increase the monthly allowance during the period of hospitalization.

Mr. Ralph Carpenter, Secretary of the Interprofessional Council, and a pharmacist, was a guest at this meeting of the Council, and was asked to give his impressions of its work. Mr. Carpenter expressed his gratitude at being permitted to attend the meeting and discussed in detail the organization and proposed work of the Council. The group was formed as a cultural,

scientific and legislative union of the five participating organizations. All of them interested in improving the health of Illinois people and in giving any information requested by legislators relative to proposed enactments which would affect health conditions. Mr. Carpenter believes that the Council will be of much benefit to the organizations represented, all interested in health, and that they will be drawn closer together in a common cause, through its operation.

MONTGOMERY reported on the efforts of himself and Fullerton to get an Auxiliary to the Southern Illinois Medical Society, but the ladies of the area preferred to remain as members at large and therefore no new Auxiliary chapter was formed.

FULLERTON recently presented four Fifty Year Club certificates and emblems. One of the recipients had taught school for 21 years before studying medicine, and yet he had completed fifty years in practice, which was unusual. He referred to a resolution approved by the St. Clair Society, which will be presented to the House of Delegates at the 1953 annual meeting, and relative to the actions of the Illinois Public Aid Commission. No action necessary at this time by the Council.

REICHERT referred to a letter received by the Secretary from Herbert Kobes, from the Division of Services for Crippled Children, University of Illinois. With it was submitted a fee schedule for use by the Division. Reichert believes that the material should be mimeographed at the Secretary's office and sent to all members with the minutes, so it can be acted upon at the meeting on January 11. Motion: (Reichert-Montgomery) that same be done. Motion carried.

MOTION: (Vaughn-Montgomery) that Council approve the sending of "Today's Health" to Illinois members of state and federal legislature, as gift subscriptions. Motion carried.

MOTION: (Blair-Sweeney) that membership of the Society in Illinois State Chamber of Commerce be renewed for 1953. Motion carried.

MOTION: (Fullerton-Newcomb) that physicians listed as recommended by component societies be elected to Emeritus and Past Service-Retired Memberships, all proven eligible for these memberships. Motion carried.

By proper action the bills as audited by the Finance Committee be approved, and Secretary instructed to pay the same. Motion carried.

Adjournment at 3:45 P. M., to meet in regular session on January 11, 1953.

Harold M. Camp, M.D.
Secretary-Treasurer

NONSPECIFIC URETHRITIS

It is true that a diagnosis of nonspecific urethritis always has a tendency to lend itself to disbelief and ridicule. Every urethral discharge must be considered specific unless proved otherwise. In this respect one should never overlook the possibility of tuberculosis. On two different occasions I have seen a persistent urethral discharge, resistant to all forms of treatment, due to the tubercle bacillus. When one considers a large group of young men undergoing severe physical training, under emotional strains, the lack of proper sexual hygiene, as we find in the armed forces, it is not difficult to understand why a nonspecific urethral discharge would be common. In a study of prostatic secretions, staphylococci, streptococci, pneumococci, and colon bacilli were noted. Gonococci were found in a very few instances. It was the feeling of the physicians who treated these men that they had a nonspecific prostatitis which in turn produced a nonspecific urethritis. It is known that the prostate may become infected from direct extension of an acute gonorrheal urethritis by way of the prostatic ducts. This is the usual method of involvement of the prostate from a nonspecific urethritis. In regard to primary nonspecific prostatitis, the method of infection of the prostate is quite different. *Theodore R. Fetter, M.D., The Early Recognition Of Prostatic Disease By The General Practitioner. West Virginia M.J. Nov. 1952.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Synovioma of the Foot

J. C. Sherrick, M.D.
Wesley Memorial Hospital

CLINICAL HISTORY

This 25-year old white female housewife was admitted to the hospital because of pain in the left foot.

PRESENT ILLNESS: The patient was well until 8 years before admission when she noted sharp pain on weight bearing in the lateral aspect of the left foot near the proximal end of the left fifth metatarsal bone. The pain was not constant but was worse with weight bearing, so that it was necessary for her to walk with the foot everted and the toes flexed. She consulted many physicians but received no relief for her symptoms. In the past 6 or 8 months there was progressive enlargement at the left 5th tarsometatarsal joint on the plantar and dorsal surfaces of the foot. The enlarged region was painful. She was admitted to the hospital for examination and treatment.

PAST HISTORY. Non-contributory.

PHYSICAL EXAMINATION: Temperature was 98.6 degree F., orally, pulse 100 per minute, respirations 12 per minute and blood pressure 138/86 mm. Hg. The patient was a well developed, obese, 25-year old white female, not acutely ill. The head, neck, heart, lungs and abdomen were normal. A poorly defined mass 3 cm. in dia. was over the proximal end of the fifth metatarsal. It was firm, tender and fixed to the underlying tissues, and extended on to the plantar surface of the foot as well as the dorsal surface. Movement of the foot, toes and ankle was not impaired and neurological examination was normal.

LABORATORY DATA: The urine was normal. The red blood count was 4,330,000 per cu. mm., the hemoglobin 13.2 gm. per 100 cc., the white blood count 10,650 per cu. mm. and the differential count showed polymorphonuclear leukocytes 59, lymphocytes 38 and monocytes 3. The Kahn was negative. X-rays of the chest were normal. X-rays of the left foot showed a poorly defined soft tissue mass involving the region of the fifth tarsometatarsal joint. It did not appear to invade the bone.

HOSPITAL COURSE: On the day after admission an operation was performed.

CLINICAL DISCUSSION

Dr. E. D. W. HAUSER:* The problem in this case is that of the differential diagnosis of

*Attending Surgeon, Passavant Memorial Hospital.

a tumor of the foot. First, we must consider tumors of the skin, which are the most common and important. I will mention verrucae, callouses, keratoses, epidermoid cysts and melanomas. None of these are seriously considered here. In general these tumors should be surgically removed although in some cases getting rid of the cause of the lesion will make surgery unnecessary. Pigmented nevi of the sole of the foot should be removed without waiting for enlargement or ulceration. My experience has been that by the time a nevus becomes malignant the patient does not live long enough to justify any major surgical procedure.

Next we must consider tumors arising from beneath the skin. First there is ganglion which may occur in the foot as well as the wrist, and which usually arise from strain or friction of some type. Usually when the irritation is removed it subsides. Tendon cysts may occur from similar causes and may similarly be ameliorated by changes in pressure or dynamics in the foot. Inflammatory lesions of various kinds occur in the subcutaneous tissue. Foreign body granulomas may follow penetrating wounds. Syphilis must always be considered, although it usually appears as a periostitis. Tuberculosis would be very rare in this situation but might occur as a tenosynovitis. A localized fungus infection would be even more rare.

A true tumor is the best possibility. A vascular tumor should certainly be considered. In this group is an arteriovenous aneurysm, but in the absence of bruit or pulsation I think we can disregard it. We have to consider also calcification of a large hematoma. Following trauma there might be myositis ossificans but either of these lesions would show calcification by x-ray. Hemangioma can be very difficult to diagnose. Sometimes flecks of calcification show in the tumor and the bone is eroded, however there may be no bony changes. Tumors arising from the bone itself should be mentioned. Exostoses may be large and generally are a reaction to inflammation. They usually subside with treatment of the inflammation or irritation. Chondroma, osteoma and giant cell tumor would be visible on the X-ray as would be bone cysts or a Brodie's abscess. A related lesion that might not appear on the X-ray would be Dupuytren's contracture. There is a fibrous hyperplasia which is usually seen in the hand but which may occur in the plantar fascia. It has the appearance of fibroma and is painful. Neurofibroma should be considered. At first this may appear as an inflammatory lesion, but later it is a bulbous well circumscribed tumor of the nerve. The pain associated with the lesion may be due to impingement of the nerve between the heads of the metatarsals. Neurilemmoma is a true neural tumor. The ones I have seen have been larger. Lipoma and fibrolipoma are rare and usually asymptomatic, although occasionally if inflamed, they may cause symptoms. Among malignant tumors one would have to think of metastatic tumor, which for practical purposes is ruled out by the absence of bone involvement in the X-ray; and primary tumor. I will consider synovioma and fibrosarcoma.

The duration of eight years speak against malignancy but from my own experience I must say that one is never certain. Even though the lesion has been present for a long time the picture suggests tumor. Synoviomas may be slow in developing and then may suddenly flare up and spread over the body. Even from a pathological report there may be a good deal of doubt as to whether a synovioma is benign or not. I approach this problem with a good deal of uncertainty as to the exact diagnosis. As far as the patient is concerned this is a questionable lesion and therefore should be removed. If I don't know what a lesion is, it is best to take it out. The x-ray appearance may help. Here we see a shadowy outline and some actual swelling. There is no calcification. If there were strands of calcification I would think of myositis ossificans. If there were flecks of calcification I would think of hemangioma. If the tumor were translucent I would think of lipoma. None of these things is present. The appearance is consistent with neurilemmoma. A fibroma should be smaller and more dense. Again I wish to say I approach all these tumors with a great deal of humility. I think the important thing to decide is what to do for the patient, and in this case there is no doubt but that the tumor should be removed completely.

DR. PATRICK RILEY: There is a vaguely defined soft tissue mass about the shaft of the 5th metatarsal bone. The 4th and 5th metatarsals are pushed apart slightly. The bone is not remarkable. I do not see any characteristics in the mass which would give a definite diag-

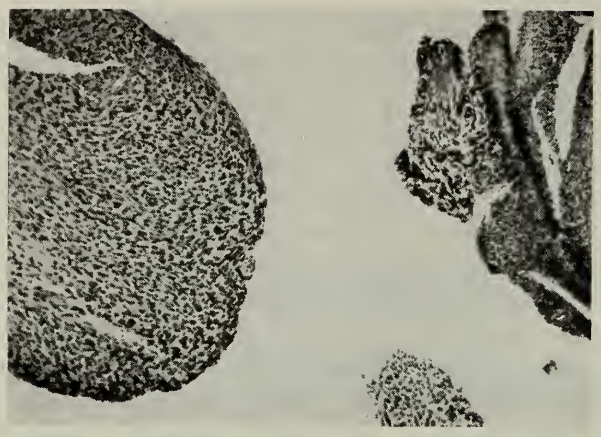


Figure 1. Section showing tumor in synovial villi.

nosis.

DR. HAUSER: A great deal that one feels with one's hands cannot be described. In this case I would be interested in the consistency of the tumor. I would like to know if it is lobulated or firm, and how much it adheres to the skin or underlying tissues.

DR. EDWARD L. COMPERE: The tumor was firm and smooth, not lobulated. It was moderately tender. It was rather fixed. Although the skin over it could be moved, it did not move well.

DR. THOMAS C. LAIPPLY: What was your diagnosis, Dr. Compere?

DR. COMPERE: First, fascial type of fibrosarcoma; second, synovioma.

DR. LAIPPLY: Don't you think eight years is too long a duration for fibrosarcoma?

DR. COMPERE: Eight years would be quite an unusual duration. I am a little skeptical of the history of eight years duration. There was a period of only six or seven months in which the patient had enough trouble with the foot to consider having something done about it. Previously she had only transient soreness in the foot. This may have been due to constant irritation from imbalance of the foot rather than tumor.

DR. HAUSER: We do not know when synoviomas start. They may be present a long time before we discover them. Their onset is characteristically insidious.

DR. LAIPPLY: Which would be more likely for an eight year history, synovioma or fibrosarcoma?

DR. COMPERE: On the basis of history alone synovioma is the best diagnosis. I considered fibrosarcoma first because of the location. Also I thought the tumor would be more firm than this was if it were a synovioma.

CLINICAL DIAGNOSIS

Fibrosarcoma or synovioma of foot.

DR. HAUSER'S DIAGNOSIS

Synovioma of foot.

ANATOMICAL DIAGNOSIS

Synovioma.

DR. LAIPPLY: At operation a tumor approximately 5 cm. in diameter was found encircling the shaft of the left 5th metatarsal bone and apparently rising from the region of the tarsometatarsal joint. As is typical of synoviomas it appeared to be circumscribed but the surgeon could not be sure that all the tumor had been removed. Microscopically the tumor was characteristic of a synovioma or synovial sarcoma. (Fig. 1) Formation of pseudoacini was prominent in some of the sections while other sections consisted of masses of spindle shaped cells that varied only moderately in size and shape. (Fig. 2) Rare mitotic figures were present and mucoid-like material was shown between the cells by special stains. Cytologically

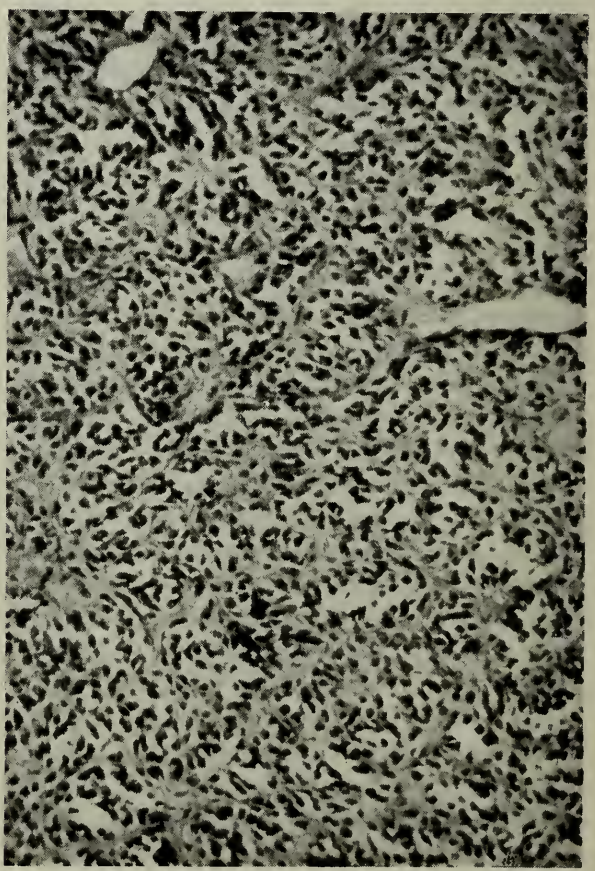


Figure 2. Section of tumor showing pseudo acini.

these tumors may appear benign but we know from experience that they are potentially dangerous and they metastasize widely. Dr. Hauser, would you care to say something about further treatment? Would you consider any additional procedure necessary?

DR. HAUSER: My experience with these tumors has been fortunate. If the tumor has been completely removed, nothing further is necessary. If not, amputation should be done. I think postoperative X-ray treatment is of little use. Metastases may be treated with X-ray when they appear, although in my experience this has not altered the course of the disease.

DR. COMPERE: A few years ago we thought there was no case of a proved synovioma surviving as long as five years. Now we know that a five year survival has been surpassed by a few but not by very many. These tumors are slow growing and slow to metastasize. Apparently they spread by extension in tissue planes long distances from the primary site so that even amputation does not as a rule prolong life. I have one patient surviving more than five years after operation; he had only local removal because he refused amputation. At present he is apparently well; in fact, he has recently been accepted by the Navy. In today's case the tumor was difficult to remove as it extended into the intermuscular planes. It was thus necessary to amputate to remove it all.

DR. LAIPPLY: Because the surgeon was not certain that all the tumor had been excised, an amputation was performed eleven days after the original operation. There was definite tumor present in the amputated extremity near the site of the original tumor, so there is no doubt but that this patient would have had further difficulty. We purposely called this tumor a synovioma rather than a synovial sarcoma because of its unusually benign appearance. I predict that this patient will do well.

Clinically these tumors enlarge rather slowly, the average duration in one series of 98 autopsied cases being 2.6 years. (1) Twenty-five per cent are preceded by a history of trauma which may or may not have significance. In 42 of the cases the average duration was 5.7 years from onset to death. The shortest survival period was 5 months and the longest 16 years. In 50 cases most of the metastases were in lungs and regional nodes. The average age of onset was 32 years, and the proportion of males to female was 3 to 2. The majority of the tumors are located in the lower extremities. When in the upper extremity the most common location is the region of the elbow.

The anatomical features of these synovial tumors are as previously described in this case. They are grossly circumscribed but unencapsulated; are nodular, firm, and may have foci of calcification. The tumors seldom project into the joint space. Microscopically the typical cell is spindle shaped, but where pseudoacinar formation is prominent, the angular character of the cells may simulate epithelium.

DR. WM. B. WARTMAN: Many of the cases reported as synovioma are doubtful. The criteria for the diagnosis should be: first, origin from synovia and second, a typical histologic picture. These tumors show wide variation in morphology and many blocks must be made. Some of the sections of this tumor look like fibrosarcoma. In general soft tissue tumors are poorly treated. Many of them recur, and may show gradual increase in malignancy in successive recurrences. Complete removal rather than enucleation is mandatory, and if this cannot be done amputation is necessary. I think biopsy and frozen section should be used more often in these cases.

DR. LAIPPLY: In my opinion frozen section is of limited value in differentiating between a well differentiated malignant tumor, such as many synoviomas, and a benign tumor. The frozen section would ordinarily establish that the lesion was a tumor but there would be uncertainty as to whether or not it was malignant. It seems to me that when the surgeon recognizes a lesion as tumor his problem is the same—i.e., complete excision, because, if incompletely removed, benign as well as malignant tumors will recur.

DR. WARTMAN: It is important to distinguish benign tumors, such as ganglioneuromas or polymorphous cell tumors from those which may become biologically malignant. The surgeon's golden opportunity is his first one, and I think every possible aid to diagnosis should be used. Frozen section is always better than visual examination.

DR. LAIPPLY: Dr. Wartman and I are evi-

1. Haagenson, C. D. and Stout, A. P.: Synovial Sarcoma, Annals of Surgery 120: 826, 1944.

dently not at all in agreement as to the value of frozen sections for diagnosis of connective tissue tumors that do not show marked cellular pleomorphism. It is my opinion that in tumors comparable to most synoviomas frozen section preparation would not accurately establish them as benign or malignant and in the present case would not have led to the correct diagnosis of synovioma.

DR. COMPERE: In our experience frozen section diagnosis has not always been accurate. I am not satisfied that this procedure would of necessity be helpful, or even without error in such cases.

SPACE MEDICINE

The present limit for motor driven aircraft has reached 55,000 feet while jet propelled aircraft has risen to 75,000 feet. We are now dealing with rockets, and for these there is no altitude limit. We know from our studies in aviation medicine that by increasing the percentage of oxygen breathed, man may be kept fully efficient up to 34,000 feet. The increase in the oxygen percentage increases the partial pressure of oxygen in the alveoli, and on this life depends. Above 34,000 feet, man becomes progressively less efficient even though breathing pure oxygen. This is because the atmospheric pressure is low that the pressure of oxygen breathed is too low to maintain efficient existence. Above the level of 34,000 feet the cabin of the plane must be pressurized, which can be done by superchargers. In so far as atmospheric conditions are concerned, complete anoxia occurs at 52,000 feet and at 65,000 feet, the body fluids will boil. At extremely high altitudes, ambient air is no longer usable for the crew. It would require too bulky equipment to compress it. When we get above 12 miles the ozone concentration is above the toxic level. Furthermore, excess water vapor, carbon dioxide, and other toxic gases must be eliminated. *Louis H. Bauer, M.D., Space Medicine. West Virginia M.J. Nov. 1952.*

BRAIN TUMORS

Brain tumors fall roughly into four classes. First are the gliomas, which are the true brain tumors, made up of glial cells. These tumors are potentially infiltrating and require excision of surrounding normal tissue before complete extirpation is accomplished. Such tumors comprise approximately 60 per cent of all tumors. At least half of the gliomas infiltrate widely, their complete removal is impossible, and their recurrence is certain. A second group of tumors is composed of fibroblasts — namely, the meningiomas and the acoustic neuromas, which comprise about 20 per cent of all brain tumors. These are not true brain tumors but intracranial tumors, since their cells are not of glial origin. They do not infiltrate the brain but crowd it to one side. If surgically accessible, they and their attachment to the meninges may readily be completely extirpated without chance of recurrence. A third group is made up of the glandular tumors, mostly pituitary in origin, with an occasional pinealoma. They account for 10 per cent of all tumors. Last, grouped together loosely, are the metastatic lesions, the congenital tumors, dermoids and epidermoids, the vascular tumors, and other varieties, again forming about 10 per cent of the entire group. *Francis C. Grant, M.D. Notes On A Series Of Brain Tumors. New York J. Med. Oct. 15, 1952.*

NEWS OF THE STATE



BUREAU

Society News.—Karl D. Nelson, Princeton, discussed "Treatment of Cardiac Emergencies" before the Bureau County Medical Society at its meeting in St. Margaret's Hospital, Spring Valley, January 13.

COOK

Eighty-Five Years of Age.—Dr. Edward H. Ochsner observed his eighty-fifth birthday, January 12. Dr. Ochsner, who graduated at Rush Medical College in 1894, is a past president of the Illinois State Medical Society.

Dr. Webster Given New Post.—Dr. Augusta Webster, a member of the Cook County Hospital since 1934, has been named chief of obstetrics at the hospital, succeeding Dr. J. E. Fitzgerald. Dr. Webster is said to be the first woman to have charge of a department at the county hospital.

New Acting Head at MTS.—Dr. Meyer Lichtenstein has been appointed temporary medical control officer of Chicago and medical superintendent of the Municipal Tuberculosis Sanatorium, to succeed Dr. Otto L. Bettag, who became state director of public welfare.

New Acting Dean at Illinois.—Dr. Roger A. Harvey has been appointed as acting dean of the College of Medicine by the University of Illinois Board of Trustees. The appointment was effective on Jan. 1.

Dr. Harvey, 42, presently serves as professor of radiology and head of that department at the University. He also is radiologist-in-chief of the University of Illinois Research and Educational Hospitals. He will continue in both of these capacities, in addition to his duties as acting dean. He has replaced Dr. Stanley W. Olson, who assumed the deanship of the College of Medicine at Baylor University, Houston, Tex., on Jan. 1.

The Board of Trustees has named Dr. Harvey to serve as acting dean until a new dean is appointed, but no later than Sept. 1, 1953. The Board has authorized the appointment of a special committee of five to be chosen by the Executive Committee of the College of Medicine to assist in the selection of a candidate for dean.

The new acting dean has been associated with the University of Illinois since 1946. He has headed the medical Betatron project since its inception in 1948. This has involved the first treatment of human cancer with x-rays up to 25 million volts, as well as the first treatment of human cancer with electrons up to 20 million volts.

During the past two years, he has authored 20 scientific papers, including chapters in three textbooks, on subjects pertaining to radiology.

He is a diplomate of the American Board of Radiology. He currently serves as vice-president of the Chicago Roentgen Society, and holds membership in the Radiological Society of North America, the American Roentgen Ray Society, and the American College of Radiologists.

Prior to joining the University of Illinois, he was associated with the University of Rochester from 1940 to 1946. During the war, he did research work for the Manhattan (atomic bomb) project. He has continued as consultant to the Atomic Energy Commission.

A native of Binghampton, N. Y., Dr. Harvey was graduated from Hamilton College in 1933. He received the master of science degree in radiology

in 1938, and the doctor of medicine degree in 1939, both from the University of Rochester.

Promotions at Illinois.—Promotions have been approved for three members of the Department of Pediatrics at the University of Illinois College of Medicine — Dr. Craig D. Butler, Dr. Benjamin M. Gasul, and Dr. C. J. Harrison.

Dr. Butler has been promoted from clinical associate professor of pediatrics to a full professorship. He has been associated with the University of Illinois since 1941. He previously was associated with Rush Medical College of Chicago, the school from which he received the doctor of medicine degree in 1919.

Dr. Gasul has been promoted from clinical assistant professor of pediatrics to clinical associate professor. He has been a member of the University of Illinois faculty since 1928. He received the doctor of medicine degree from Rush Medical College in 1925, and the master of science degree from the University of Illinois in 1937.

Dr. Gasul has served as director of the Pediatric Cardio-physiology Department at Cook County Children's Hospital since 1946. He is a professor of pediatrics at the Cook County Graduate School of Medicine.

Dr. Harrison has been promoted from clinical assistant professor of pediatrics to clinical associate professor. He has been associated with the University of Illinois since 1941. His affiliation with Rush Medical College dates back to 1930. He received the doctor of medicine degree from Northwestern University in 1927.

DeKALB

Society Chooses Officers.—Dr. H. J. Trapp, Sycamore, was inducted into the presidency of the DeKalb County Medical Society at its next meeting, December 30. Dr. E. F. Glenn, DeKalb, became vice president and president-elect, and Dr. C. E. Clark, Sycamore, was reelected secretary-treasurer. Dr. J. C. Ellis, DeKalb, was named state delegate to the Illinois State Medical Society; Dr. Clark, alternate delegate, and Drs. C. E. Smith, DeKalb, J. F. Eggers, Sycamore, and D. J. Ladd, DeKalb, were named to the board of censors for the respective terms of one, two and three years.

GREENE

Society Election.—Officers of the Greene County Medical Society, elected at its meeting December 10, are N. J. Bucklin, Roodhouse, president; W. T. Stickley, White Hall, vice president; and Paul A. Dailey, Carrollton, reelected secretary-treasurer. Dr. E. G. De Quevado, Greenfield, was elected to the board of censors.

HENRY

Society News.—Dr. F. E. Bollaert, East Moline, addressed the Henry County Medical Society, January 22, on "Recent Suggestions for Elaboration of Medical Ethics."

LAKE

Society News.—John C. Sylvester, Ph. D., chief of the department of bacteriology, Abbott Laboratories, addressed the Lake County Medical Society at the Lake County Tuberculosis Sanatorium, Waukegan, January 13, on "Antibiotics—Past, Present and Future."

New Officers.—Dr. W. R. Darnall, Waukegan, was chosen president of the Lake County Medical Society, December 9, Dr. J. Frederick Lutz, Lake Forest, vice president; Dr. Gerrit Dangremond, Waukegan, secretary; and Dr. Earl Klaren, Libertyville, treasurer. Dr. Morley McNeal, Highland Park, was elected to the board of censors for three years; D. Donald Douglas, and L. E. Bovik, both of Waukegan, to the grievance committee for three years. Dr. A. L. Myers, Waukegan, was named chairman of the grievance committee; Dr. Robert Watrous, North Chicago, was named delegate to the Illinois State Medical Society for two years, and Dr. George Callahan, Waukegan was named alternate delegate. Dr. John Ward, Lake Bluff, was named to the grievance committee to fill out the unexpired term of the chairman.

LAWRENCE

Vote to Retain Health Department.—The people of Lawrence County voted 5 to 4 in the November 4 election against "discontinuance of the Lawrence County Public Health Department", according to the *Illinois Health Messenger.*

MACON

New Society Officers.—New officers of the Macon County Medical Society are Drs. C. E. Bell, president; F. G. Irwin, president-elect; Maurice D. Murfin, secretary; Ferris D. Highsmith, treasurer. Dr. Maurice D. Murfin was designated delegate to the Illinois State Medical Society, and Dr. Edward S. Lockhart, alternate delegate.

ROCK ISLAND

Society News.—At a meeting of the Rock Island County Medical Society in the Moline Public Hospital Auditorium, January 13, Dr. Paul H. Holinger, Chicago, spoke on "Changing Aspects of Esophageal Disease."

SANGAMON

Society News.—"Modern and Practical Concepts of Anxiety States" was the subject of Dr. E. H. Parsons, assistant professor of psychiatry, Washington University School of Medicine, St. Louis, before the Sangamon County Medical Society, January 8.

New Pathologist.—Dr. David O. Holman assumed the duties of pathologist at St. John's Hospital, Springfield, December 15. He had been practicing in Rockford since 1941.

VERMILION

Society News.—Dr. William Lees, Chicago, discussed "Early Diagnosis of Chest Lesions, Especially Cancer of the Lung" before the Vermilion County Medical Society in Danville, January 6.

Society Election.—Dr. John Mason was elected president of the Vermilion County Medical Society in December; Dr. Ray Bucher, vice president, and Dr. Donald Dickerson, secretary-treasurer. Dr.

Jean Moore was designated delegate to the Illinois State Medical Society and Dr. Arthur Brandenberger, alternate.

WINNEBAGO

Society Acts on Indigents.—The Winnebago Society on November 2, 1952, adopted a motion favoring the continuation of medical and surgical services to the indigent patients at the Winnebago County Hospital and Home for an additional period of six months under the old agreement with the Winnebago County Hospital and Home Committee. A re-evaluation of the program will be made at the end of that time.

The President of the Winnebago County Medical Society then designated the officers of the staff of the County Hospital as a "Staff Committee" to work with the Liaison Committee in superintendence of the professional services at the hospital in behalf of the Society.

In response to this directive the Staff Committee respectively submits the following plan for operation for the approval of the Society:

1. The patient will select his own physician, and this physician will continue on the case as long as the patient requires treatment in the hospital.

2. The physician chosen will be notified by the nurse in charge when his patient is admitted. He will transmit his orders and will visit the patient within twenty-four hours or sooner if an emergency exists.

3. In the event the physician selected by the patient is unwilling or unable to care for his patient, he is then to designate the physician of his choice, indicating such choice to the nurse or other official who calls him, and he will notify the physician of his choice immediately. The so designated physician will then function as outlined in paragraphs one and two.

4. The Staff Committee will provide a roster of physicians who will be subject to call by the hospital when a patient is admitted who is unable or indisposed to designate a physician of his choice or when such physician in unavailable. This roster will be selected by the Executive Secretary in rotation from the participating general practitioners, general surgeons, and internists of our Society. The term "participating" will be clarified in a subsequent paragraph. Each physician on call will be notified by card from the Executive Secretary two weeks in advance. His duties will be briefly outlined on the card.

5. A roster of participating consultants will be made up by the Staff Committee and posted at the hospital to aid in selection of the appropriate consultant when such services are desired. All specialists who wish to participate in this program may do so by indicating their willingness to serve to the Staff Committee.

6. Decisions as to the type of cases which may be cared for and the extent of the professional services which may be rendered in the County Hospital will be a joint function of the Liaison Committee, and the County Hospital and Home Committee. Permission to transfer major surgical and medical cases to private hospitals has already been approved by the County Hospital and Home Committee. These patients should be returned to the County Hospital as soon as possible.

7. The Staff Committee will have no jurisdiction over the contagion and polio ward.

8. If the County Hospital and Home requires advice in regard to drugs, food, nursing care, equipment, etc., such a function will be the responsibility of the Liaison Committee.

9. All members of the Society will be given an opportunity to designate on an appropriate card their willingness to participate in the care of indigent patients at the County Hospital.

10. All physicians who express their desire to participate will thereby subscribe to these proposals and will co-operate in every way possible towards the best interests of the patients and the County Hospital. These physicians will be designated as "Participating Physicians." A list of these men will be published in the Bulletin, and posted in the hospital.

11. In cases of dispute or misunderstanding the Staff Committee will attempt to reconcile or clarify any differences of opinion. If unsuccessful, the Executive Committee of the Society will be the final arbiter.

GENERAL

All Time High for Polio.—The number of polio cases recorded in Illinois last year reached an all-time high of 9,931, the state Department of Public Health reported recently.

The 1952 total exceeded by more than 1,000 the previous high of 2,910 cases in 1949.

Among other major reportable diseases, however, the trend in 1952 was downward. Incidence set new record lows in such diseases as diphtheria, typhoid fever and whooping cough.

Only 15 cases of diphtheria were reported last year. In 1951 there were 28. Typhoid fever was diagnosed in 41 cases against 57 in the preceding year. Whooping cough, which in 1951 struck 1,452 persons, fell to 719 last year.

For the fifth consecutive year not one case of smallpox was reported in Illinois. This contrasts with the record of smallpox back in the 1920s when at least one death was attributed to the disease in each year of that decade and which caused 26 deaths in the year 1921. Vaccines are given credit for bringing smallpox under control.

Syphilis cases continued to decline in 1952 when 7,723 cases were reported. In the preceding year there were 9,669 cases.

DEATHS

George S. Connelly, Mount Pulaski, who graduated at Barnes Medical College, St. Louis, in 1909, died November 25, aged 73, of carcinoma.

Wilbur E. Coulter, Seneca, who graduated at Northwestern University Medical School in 1910, died in October, aged 69.

Ulysses G. Darling, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago in 1890, died December 15, aged 86. He had practiced medicine in Chicago for 58 years.

Albert E. De Riemer, retired, Chicago, who graduated at Jenner Medical College, Chicago, in 1915, died January 8, aged 78.

Joseph Eisenstaedt, retired, Chicago, who graduated at Northwestern University Medical and Dental School in 1909, died December 18, aged 67.

George E. Gilman, Streator, who graduated at the University of Illinois College of Medicine in 1936, died December 16, aged 43.

Ralph T. Hinton, Quincy, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1904, died December 19, aged 71.

Charles E. Mayos, retired, East Moline, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died December 19, ager 74. He had served as member of the staff of East Moline State Hospital for 31 years.

Louis S. Robins, Chicago, who graduated at Northwestern University Medical School in 1926, died January 8, aged 55.

Mary Gritzner Schroeder, Wilmette, who graduated at Rush Medical College in 1921, died November 16, aged 83, of coronary insufficiency and arteriosclerosis. She was a member of the American Psychiatric Association; past president of the Chicago chapter of the Women's Medical National Association; for many years clinical associate in medicine, neurology, and psychiatry at her alma mater.

Roy Sexton, retired, Streator, who graduated at Northwestern University Medical School in 1894, died recently, on his 84th birthday.

Elza F. Tate, Plainfield, who graduated at Chicago College of Medicine and Surgery in 1914, died December 12, aged 65.

George F. Tyson, Evanston, who graduated at National Medical University, Chicago, in 1898, died January 8, aged 80. He had practiced medicine in Evanston for more than 50 years.

James A. Valentine, River Forest, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died December 30, aged 65. He was senior surgeon at Loretto Hospital.

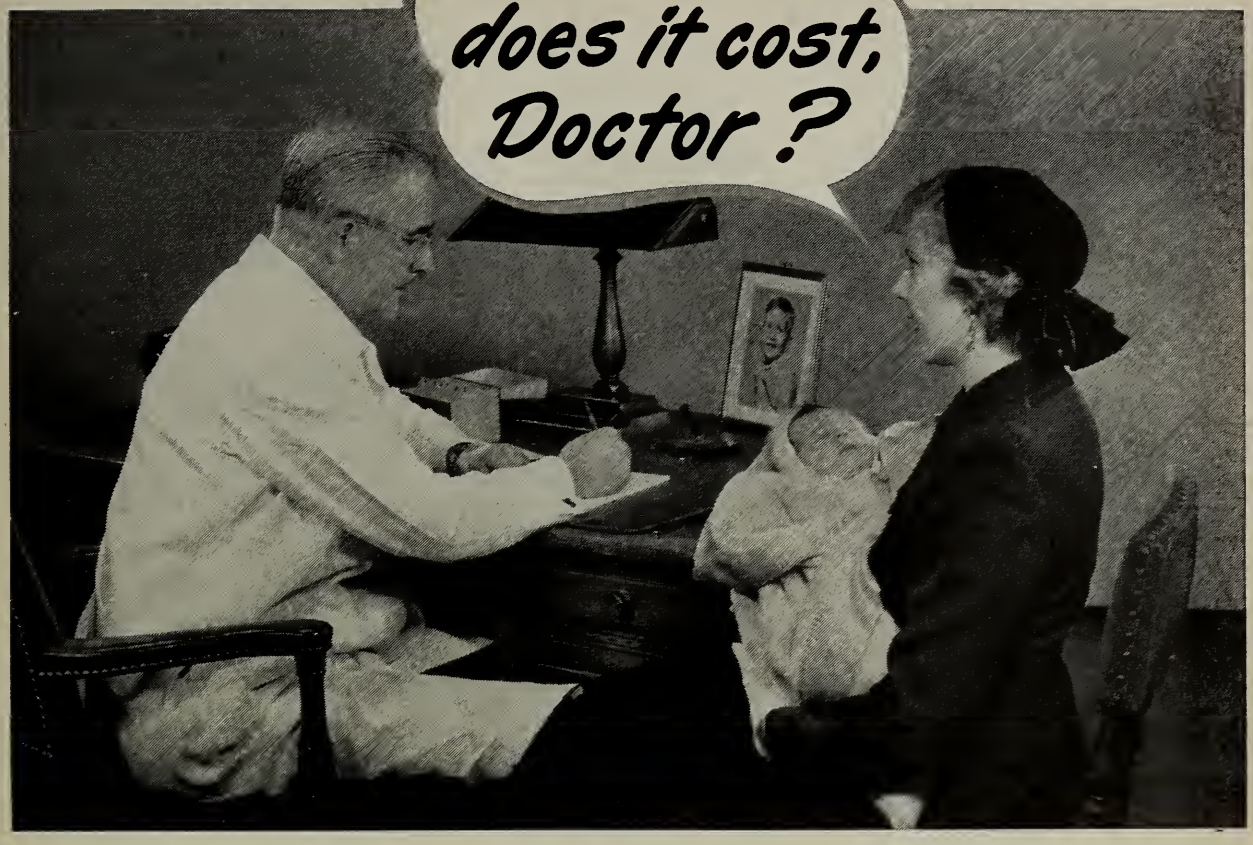
Chester A. Washburn, retired, Chicago, who graduated at the Hahnemann Medical College and Hospital in 1908, died December 22, aged 71.

Joseph E. Westerlund, Cambridge, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, died in Kewanee Public Hospital, September 6, aged 82, of cerebral hemorrhage.

ON PHYSICIANS

One who knows doctors well cannot but like them and have a tender feeling for them. The very nature of their work appeals to one. It has well been said that "physicians have undoubtedly helped to put a kindlier feeling into humanity." That testimony is true and if there were no other reason, that alone should give them a secure place in the hearts of their fellow men. But the doctor is not dependent upon that claim for the affectionate regard of men. Other reasons abound. His service to the race has been and is inestimable. The roster of the world's great men is incomplete without the names of many distinguished doctors. In my judgment doctors have not been given their proper place in history. Long it has been a matter of wonder to me that our schools give such disproportionate attention to the great warriors of the past while those who have served mankind in the quieter, gentler realms of peace are generally neglected. Every school child early is made familiar with the Alexanders, the Caesars, the Napoleons, the Wellingtons, and the Hitlers of history; men whose way to greatness has been hideous with the dead and mangled bodies of the slain over which they have marched. The smoke of destruction has darkened their paths and above the acclaim of their victorious hosts is heard the wail of suffering from multitudes of new-made widows and orphans. *Louis J. Bristow, D.D., Address. New Orleans M. & S.J. Nov. 1952.*

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



CONSERVATIVE MANAGEMENT OF THE LOW BACK SYNDROME

Robert Brashear, M.D. In THE JOURNAL OF THE TENNESSEE STATE MEDICAL ASSOCIATION, 45:7:267, July 1952.

The various therapeutic measures available for conservative treatment of low back pain should be divided into those employed for the treatment of pain, and those employed in the protection an rehabilitation of the weak back. These measures overlap a great deal and the rehabilitation program may be used for the postoperative weak back as well as the weak back not operated upon.

Manipulation should be considered first, not because its general use is advocated, but because it should be disposed of. We have been scientifically trained not to do things which we do not fully understand, and so far no one has adequately explained exactly what happens when an acute attack of low back pain is suddenly and completely relieved by manipulation.

Back strapping is useful and simple. Bed rest is considered the best treatment for low back pain, and all cases of severe back pain with sciatica should be hospitalized. Traction places a mild but steady pull on spastic muscles thus overcoming and relieving their spasm, and also has the very great advantage of keeping the patient in bed.

Heat and massage once or twice daily add greatly to the patient's comfort and help relieve muscle spasm. An electric pad to the sore area one hour out of every four often is helpful and even the counter-irritant effect of strong liniments is worthwhile.

In the rehabilitation of the weak back, heat and massage may be used. Patients are started on postural exercises as soon as pain permits, A qualified physical therapist is most important, for he will not only teach the patient to do the exercises which have been prescribed but will help to convince the patient that the exercise program is the one thing that will prevent recurrences. The exercises used are very simple and very brief. The development of good body mechanics is most essential, and the patient must be taught to associate good posture with those things he does often and in private.

COMBINATION THERAPEUTIC TANK AND POOL

Samuel Sverdlik, M. D. In ARCHIVES OF PHYSICAL MEDICINE, 33:8:486, August 1952.

A tank incorporating features of many existing therapeutic tanks and pools is described in this article. It was designed for use in acute conditions in a general hospital and requires moderate initial outlay and maintenance.

(*Continued on page* 42)

Greater Relief in the COMMON COLD



The concept that allergic tissue responses are important contributory factors in upper respiratory infections, particularly the common cold, has been widely accepted. To combat these allergic manifestations more successfully, Thenfadil — one of the most effective and best tolerated antihistaminics — has been combined with the time-tested A.P.C. formula commonly used for the symptomatic treatment of the common cold.

Thenfadil A.P.C. appears to be more effective in shortening the disease the earlier it is used at the onset of a cold. In established cases Thenfadil A.P.C. alleviates headache, fever, malaise as well as generalized aches and pains.

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Each tablet contains:

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Phenacetin	0.2 Gm. (3 grains)
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Supplied in bottles of 50 tablets.

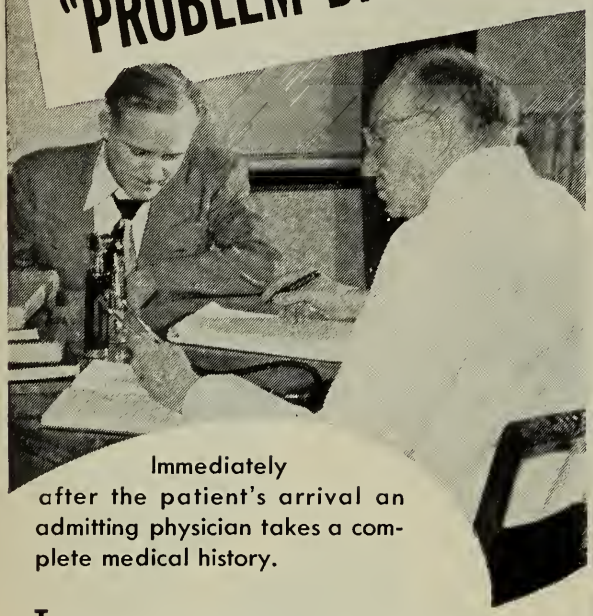
dose:

Adults, 1 tablet as soon as possible at the onset of a cold; thereafter 1 tablet every four hours for three or four days. A similar dosage is indicated for the symptomatic treatment of established colds.

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Immediately after the patient's arrival an admitting physician takes a complete medical history.

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The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

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Physical Medicine (Continued)

A perforated steel platform occupies the entire inner surface of the tank and can be placed at any desired height or inclination. By inclining the platform, the degree of buoyancy is modified in the shallow portion and exercise value is derived from the added resistance of the body. Likewise, by raising the platform, children can be treated for gait training at a uniform working height. With the platform at its uppermost resting level, the water depth allows for underwater exercises.

This tank has been found useful for a variety of conditions, such as arthritis, poliomyelitis, back pain, chronic phlebothrombosis of the lower extremity, decubiti, lower extremity and pelvic fractures, as well as upper extremity fractures.

THE ROLE OF PHYSICAL MEDICINE IN THE MANAGEMENT OF THE UPPER EXTREMITY AMPUTEE

Raoul C. Psaki, Lt. Col., M.C., U.S.A., and Anielio F. Mastellone, Lt. Col., M.C., U.S.A. In UNITED STATES ARMED FORCES MEDICAL JOURNAL, 3:4:627, April 1952.

The rehabilitation of the upper extremity amputee is a five-point program, and each phase in the process is equally important to its ultimate success. The psychologic preparation of the patient is vital to the success of the program and should be the responsibility of all concerned with the management of the patient. The orthopedist evaluates the patient's surgical needs and provides an adequate stump. The physiatrist is concerned primarily with the pre- and postprosthetic training of the amputee. This phase of the program is extremely important because the amputee must be encouraged to use the prosthesis and obtain the maximal functional benefit from it, particularly in bimanual activities.

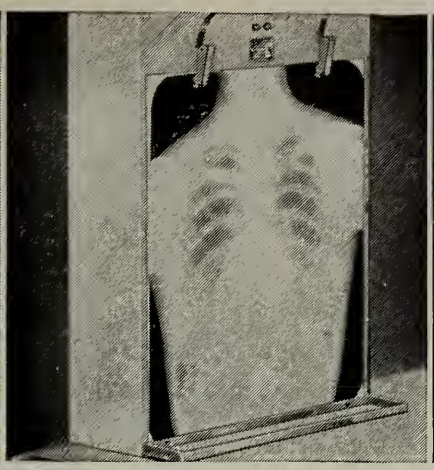
The loss of an upper extremity produces a change in the patient's center of gravity and may produce defects of postural alinement, contractures, and muscular imbalance which will compromise the optimal functional result. Physical measures designed to prevent and correct these deformities should be instituted as early as possible. When physical therapy is started the patient should be indoctrinated in the importance

(*Continued on page 44*)

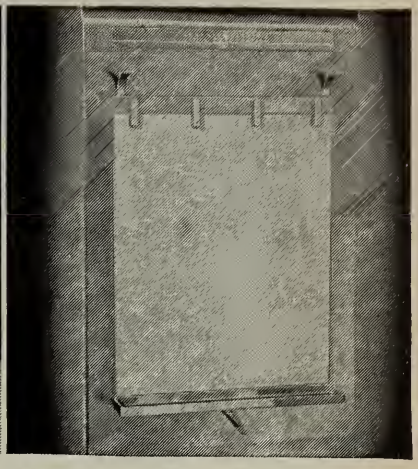
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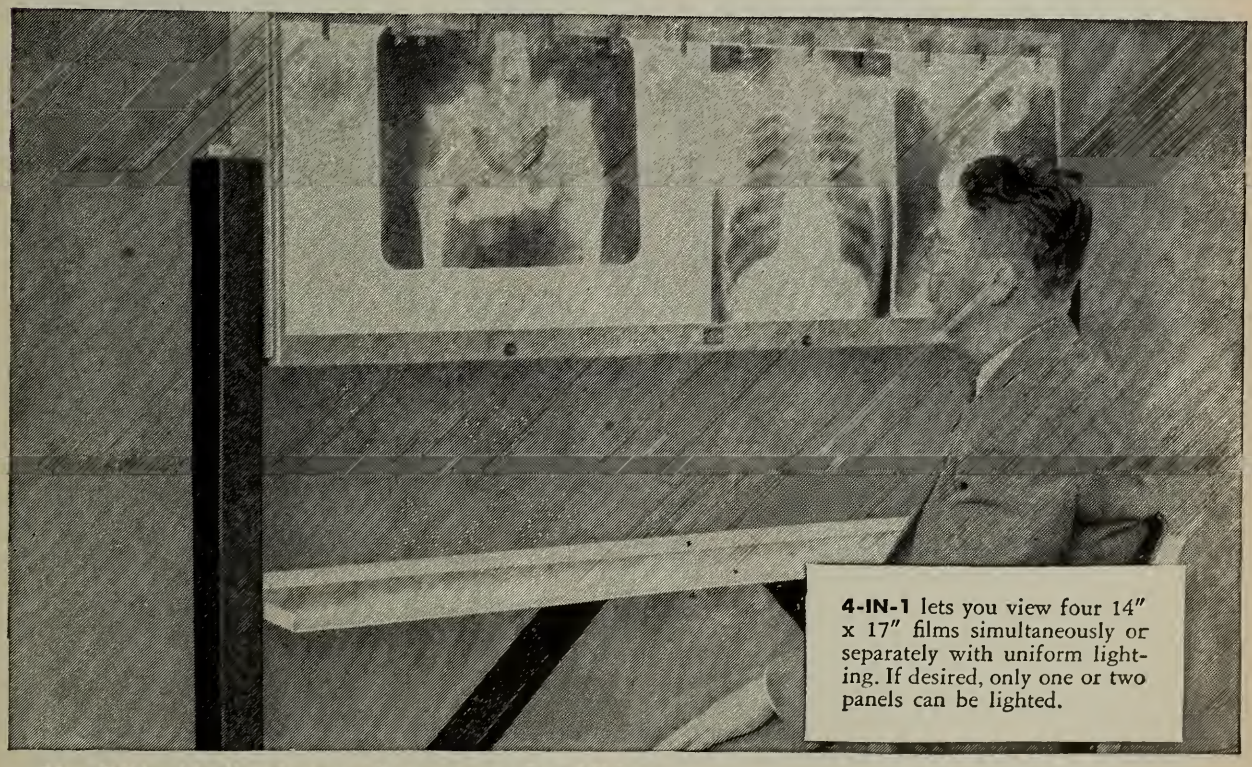
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Physical Medicine (Continued)

of postural exercises. The definitive preprosthetic measures are determined by an evaluation of the patient with respect to: (1) postural alinement, (2) joint mobility, (3) muscular strength, (4) the presence of pain, and (5) the condition of the stump.

The treatment program consists of general measures such as mat exercises designed to overcome deconditioning, postural defects, and muscular atrophy and weakness; and specific measures such as the judicious use of heat, massage, proper bandaging of the stump, and therapeutic exercise to the involved extremity. Adequate mobility of the proximal segments of the extremity must be assured in order that the greatest functional use of the prosthesis may be obtained. Thus the mobility of the scapulas is of prime importance, particularly in patients who will be fitted with the shoulder-harness type of appliance. The degree of ultimate usefulness of the prosthesis depends on the active mobility of the shoulder girdle.

MANAGEMENT OF MULTIPLE SCLEROSIS

Hinton D. Jonez, M.D. In POSTGRADUATE MEDICINE, 11:5:419, May 1952.

Physical therapy is of great value in the chronic cases of multiple sclerosis. Nonparalyzed, atrophic and weak muscles become functional again as a result of such therapy. Coordination exercises and muscle reeducation are part of this program. Badly contracted limbs are straightened with hot packs, simple orthopedic procedures and braces. Various types of canes and crutches are useful in getting patients out of wheel chairs and walking again. However, short rest periods taken periodically during the day are beneficial and usually are necessary.

As an adjunct to physical therapy, voluntary muscle relaxation is very important. The principal drugs used for this effect are prostigmin, myanesin and curare. The latter has proved to be most valuable in the opinion of Jonez.

Treatment as outlined by Jonez does not cure, but it does arrest symptoms a great many times. Above all, it holds out hope to these patients with reference to their future. Bedfast cases have been made ambulatory or wheel chair cases, and wheel chair patients have been made ambu-

(*Continued on page* 46)



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Physical Medicine (Continued)

latory. Still others have become symptom-free and remained so without an exacerbation up to periods of over five years. This is more than can be done for many other chronic diseases.

THE REHABILITATION OF THE HEMIPLEGIC

Herman J. Bearzy, M.D. In THE OHIO STATE MEDICAL JOURNAL, 48:5:409, May 1952.

Since not all hemiplegics can be aided by rehabilitation, it is necessary first of all to exclude those cases in which the pathological processes will prohibit many of the physical activities that are required in a rehabilitation program. Careful evaluation must be made of the physical and mental status of the patient with hemiplegia. The physiatrist is consulted to determine the strength of both the affected and normal muscles; to check the range of motion of the involved joints, and to institute early procedures for the prevention or correction of contractures or deformities. The physiatrist also should perform the activities of daily living test to determine the amount of functional disability present.

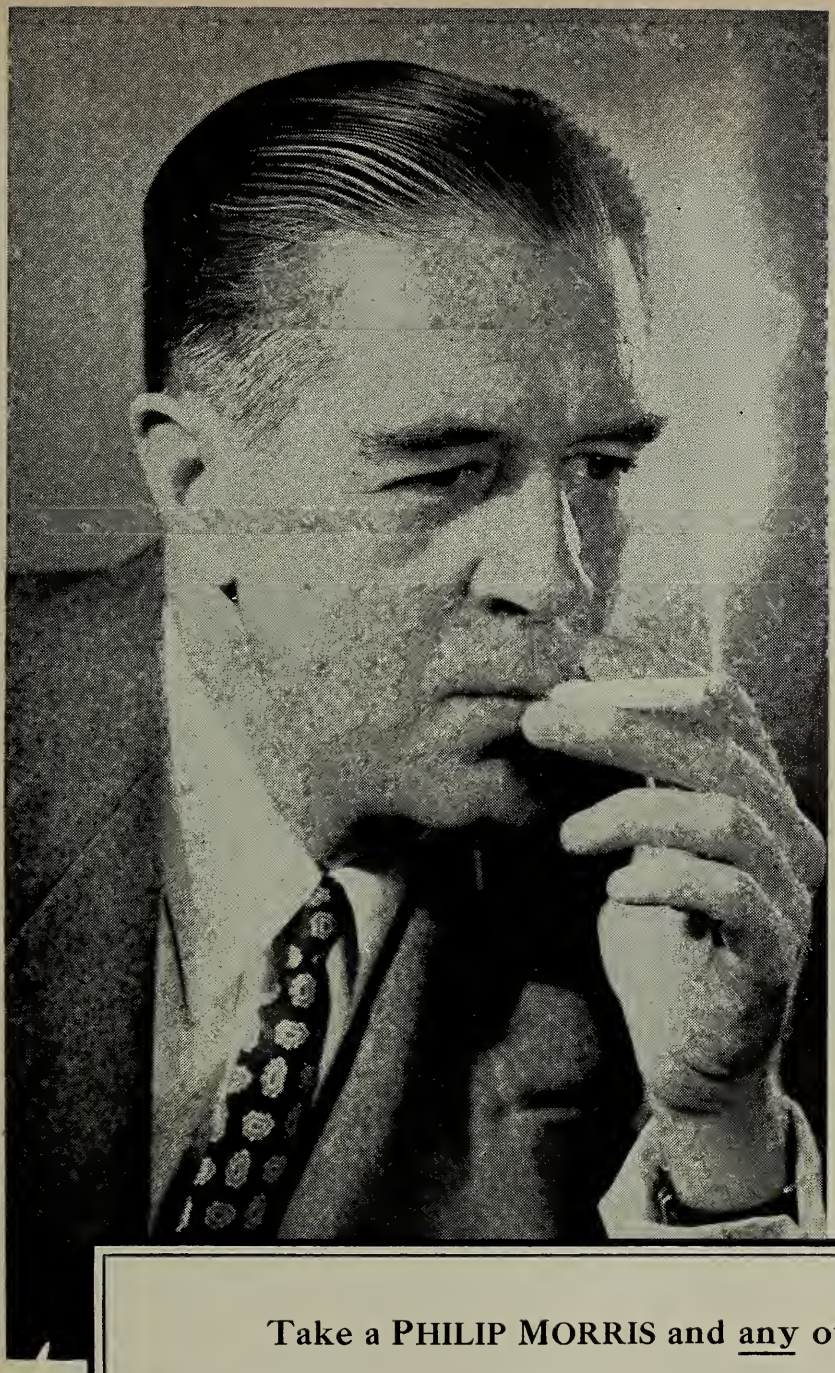
After careful evaluation of the patient has been accomplished, the internist, neurosurgeon and physiatrist work as a team to plan for the immediate and long term care of the patient. Treatment may be considered in three phases: (1) medical care of the apopletic stroke during the immediate onset; (2) medical management of the resultant hemiplegia, and (3) those physical activities that aim to rehabilitate the individual to a life of usefulness and self independence.

Physical therapy in the first stage consists of heat and massage to alleviate pain and spasticity, and to prepare the extremities for passive stretching motions. Electrotherapy also has been of some value as an aid in muscle reeducation and in helping to overcome certain fixed deformities which most hemiplegics tend to develop.

The second phase of the treatment of the apoplectic stroke consists of those activities directed towards the residual hemiplegia to improve neuromuscular coordination, muscle function and muscle strength.

Bedside rehabilitation activities, after the

(*Continued on page* 48)



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acute phase of the illness is over, should consist of a continuation of passive exercise and pulley therapy.

The third and final stage of the rehabilitation program attempts to improve functional performance by retraining the patient in ambulation, reestablishing function and coordination in the affected upper extremity, improving speech performance, and establishing a good home program for the patient when he is finally discharged from the hospital or clinic.

Advanced ambulation training may be carried on in the rehabilitation department or in the patient's home. Active resistive or progressive resistive exercises are given to strengthen all affected muscle groups preparatory to full ambulation. Posture exercises are given to correct any postural defects that may be present. The patient then progresses to walking between parallel bars, and finally with crutches or canes.

The affected fingers and hand of the hemiplegic are the last to recover any useful function. Since most cases fail to recover full functional use of the involved hand, it is important that one-handed skills with the unaffected hand be started early and continued until the patient has regained adequate function in the affected hand to perform the activities essential to daily living. The rehabilitation of the spastic arm should begin with a series of exercises directed towards increasing and improving motion first in the shoulder, then in the upper arm, forearm, and hand. Re-education exercises, similar to those used in poliomyelitis, are required to retain these muscles for normal functional movements. Once the normal pattern of motion has been reestablished, muscle strengthening and coordination exercises can be prescribed.

COMPLETED MEDICINE—REHABILITATION

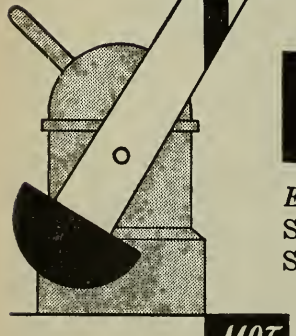
Nila Kirkpatrick Covalt, M.D. In JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, 7:1:9, January 1952.

The dynamic therapy in the treatment of any acute or chronic disease should be treatment of the whole man. It is not enough to make a brilliant diagnosis, or save a life, then send the

(*Continued on page* 52)

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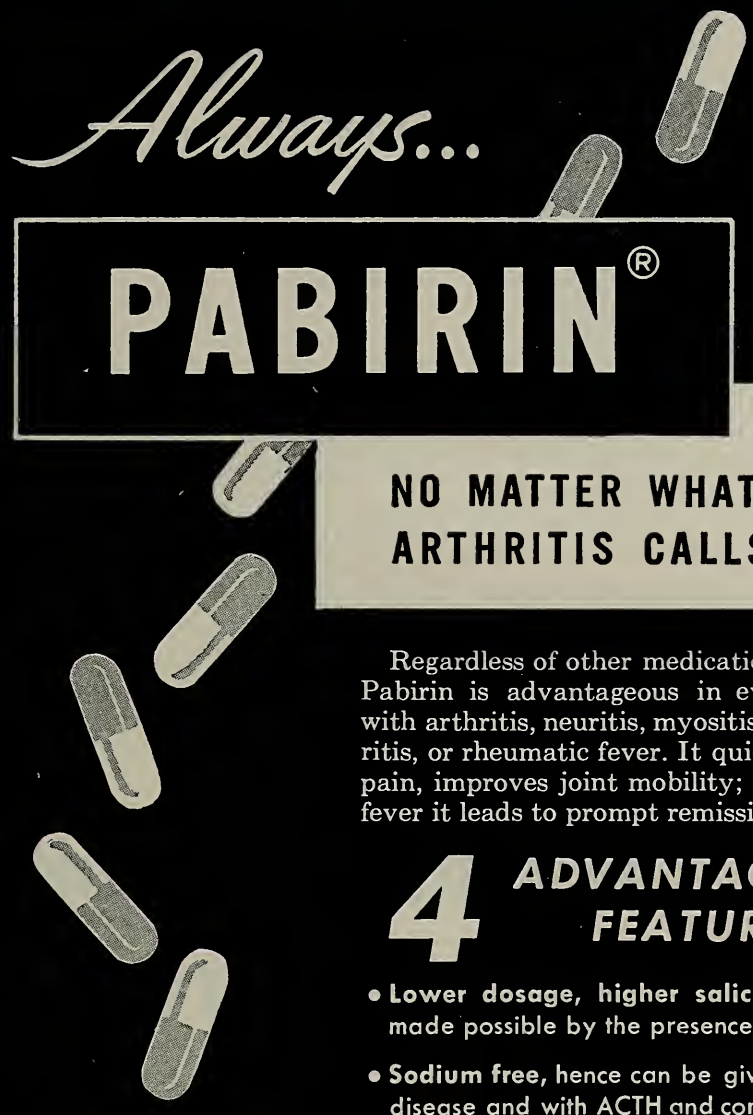
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patient home to vegetate. A patient with a physical disability should be taught to be physically self sufficient. Assistance should be given to help an individual readjust to any mental trauma which may have occurred as a result of the illness. Many patients need assistance and advice in regard to returning to their previous occupations, or may need to be re-trained for new jobs suited to their remaining capabilities.

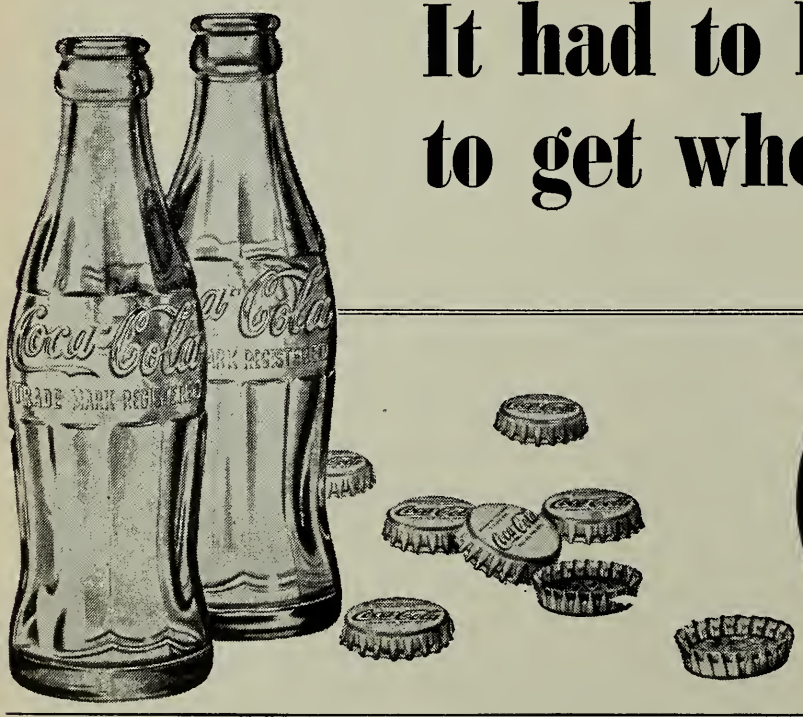
Any patient who has had a cerebral vascular accident can be taught to walk again, if he has the desire to do so. Medical complications which need confine such individuals to bed for the remainder of their lives are rare. A similar situation is too prevalent with civilians who have had amputations.

It is unfortunate when civilian individuals with static physical disabilities, such as the hemiplegics, the amputees, the paraplegics, and the victims of poliomyelitis are not physically rehabilitated. All of these patients should be taught self care to the maximum of their remaining capabilities. There are no specific rules or technique, except that from the standpoint of body mechanics certain methods should work best with each disability.

The achievement of physical independence is of the utmost importance in restoring an individual's self respect. If the individual can be made economically self sufficient again, the financial gains to himself and his community are tangible gains. Every individual who is physically self sufficient saves money for himself or for others. Financial gains alone are measurable, but the restoration of self respect and happiness to an individual is of far more importance.

In general, patients with minimal pulmonary tuberculosis should not undergo chemotherapy, because most of them derive as much benefit from ordinary methods of treatment. In any event, the importance of correlating chemotherapy with other methods of treatment cannot be stressed too greatly. Chemotherapy is not a substitute for prolonged bed rest, and the proper timing of the addition of collapse therapy, when appropriate, should be planned in each case on an individual basis, at the outset. William S. Schwartz, M.D., the J. A. M. A., February 23, 1952.

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BOOK REVIEWS



A Course in Practical Therapeutics by Martin Emil Rehfuss, M.D., F.A.C.P., Professor of Clinical Medicine and Sutherland M. Prevost, Lecturer in Therapeutics, The Jefferson Medical College, Philadelphia; Attending Physician, The Jefferson Medical College Hospital, Philadelphia. Alison Howe Price, A.B., M.D., Associate Professor of Medicine, The Jefferson Medical College, Philadelphia; Asst. Physician to the Jefferson Medical College Hospital, Philadelphia; Chief of Diabetic Clinic, Curtis Clinic, Philadelphia. Second Edition. Baltimore, The Williams & Wilkins Company, 1951.

This is a large volume primarily designed for the student of medicine or the young man just starting in private practice. However, because of its logical development of subject matter, excellent index and fine drawings, illustrations and detailed charts, it makes for a handy reference book for the busy practitioner.

It is divided into four main sections. The first section deals with the general principles of therapeutics. Here the authors have stressed the value of a well-planned program of investigation into the cause of disease followed by logical sequence of treatment. It deals with prescription writing, basic drugs, diets, nursing problems and even enumerates the contents of a physicians bag.

The second section is devoted to symptomatic therapy. Most of the common symptoms of disease are considered and a differential diagnosis is listed. At the conclusion of the discussion of each symptom, a routine program of treatment with the use of the representative drugs is offered.

The third section covers specific disorders found in internal medicine with the exception of the nervous system. The authors feel that neurology and psychiatry may best be covered in a separate volume.

The concluding section attempts to cover some of the specialties in medicine and therapeutics such as atomic warfare, radioactive isotopes, pediatrics and oxygen therapy to mention but a few of the twenty-one subjects under consideration.

J.W.P.

Ophthalmic Pathology. An Atlas and Textbook. By Jonas S. Friedenwald, Helenor Campbell Wilder, A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens, with the editorial assistance of Helen Knight Steward. Published under the Joint Sponsorship of the American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. 489 pages with CCLX Plates. Philadelphia and London: W. B. Saunders Company, 1952. Price $18.00.

The publication of this book has been an event long anticipated by all students of ocular pathology. An outgrowth of the Atlas of Ophthalmic Pathology previously prepared by DeCoursey and Ash on the basis of the enormous collection of pathological material in the Army Medical Museum it has been developed with painstaking care into as complete an exposition of the subject as is to be found in the opthalmic literature. Using Friedenwald's "Pathology of the Eye" as a basis for the text the distinguished committee of ophthalmic pathologists has labored arduously and with complete success to produce an authoritative, modern, and comprehensive treatise on ophthalmic pathology.

The descriptive material is arranged logically into various chapters, each of which is followed by numer-

(*Continued on page* 56)


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BOOK REVIEWS (Continued)

ous illustrations, mostly from the voluminous files of the Armed Forces Institute. It is unfortunate that the cost of reproducing these plates in color would have been prohibitive since their value to the casual reader would have thus been enhanced. To the earnest student this will not be a serious deficiency since the black and white photomicrographs are well chosen and satisfactorily reproduced. The text is clear, concise and yet complete, written with a facile literary style which makes it understandable to the novice as well as to the more experienced pathologist. For that reason the book will prove invaluable to the neophyte in ophthalmology, whose training is frequently deficient in pathology but who must master the rudiments for his American Board examination. Later he will have occasion to refer to it for a better pathological understanding of some of his more perplexing clinical cases.

The American Academy of Ophthalmology and Octolaryngology, the Armed Forces Institute of Pathology, and particularly the authors directly responsible are to be congratulated on producing this outstanding atlas and textbook and thereby making one of the most significant contributions of our time to the understanding of ophthalmic pathology.

W.A.M.

THE CLINICAL USE OF FLUID AND ELECTROLYTE: By John H. Bland, M.D., Assistant Professor of Medicine, University of Vermont College of Medicine. 259 pages with 75 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $6.50.

This monograph is one of a series stated by the publisher to have been produced inexpensively in order to be available to a wider audience. It is paper bound but printed attractively on good quality paper. Although the type is somewhat smaller than in most medical books, it is perfectly legible. One might wish that the pages had been divided into two columns for easier reading, but this is a small disadvantage.

It will be interesting to note the response of the medical public to these monographs. Surely decrease in cost of medical publications is for the best interests of the publisher as well as the reader.

The monograph succeeds well in its stated aim—that of providing a practical guide to the recognition and treatment of fluid and electrolyte abnormalities that may arise in disease.

The introductory chapters include basic physiological concepts of body fluid and electrolyte balance, based largely on Gamble's work. Other chapters discuss changes in heart failure, pediatric and geriatric patients, surgical patients, kidney disease, diabetes and adrenal cortical disease. The book concludes with a chapter on the changes in body water and electrolyte in shock, burns, crush and blast injuries, X-irradiation, cold and other stresses. Abnormal potassium metabolism and lower nephron nephrosis are fully discussed.

This monograph is well written and up to date. It

(*Continued on page* 58)

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H. J. Carr, M.D., Staff Physician.

BOOK REVIEWS (Continued)

should be useful if not essential to clinicians as well as laboratory workers.

J. C. S.

BIOCHEMISTRY FOR MEDICAL STUDENTS: By William Veale Thorpe, M.A. (cantab.), Ph.D. (Lond.), University of Birmingham. 5th ed., 528 pages, 41 illustrations. Lippincott, Philadelphia, 1952. Price $6.00.

This is the fifth edition of this popular textbook of biochemistry since 1938. It makes an attempt to cover the many advances that biochemistry has made since the last edition in 1947. Progress in biochemistry has been so rapid in recent years that any text is somewhat outdated before it comes to print; however, this book does include enough material to provide an adequate background for the student.

The most significant recent advance covered is the establishment of the tricarboxylic acid cycle of Krebs, and the chapters on metabolism have largely been recast and rewritten in proper perspective to this.

A chapter on food costs is included in the section on nutrition; its value is slight because of the change in food prices since it was compiled.

On the whole, the book provides a satisfactory reference for the student of biochemistry.

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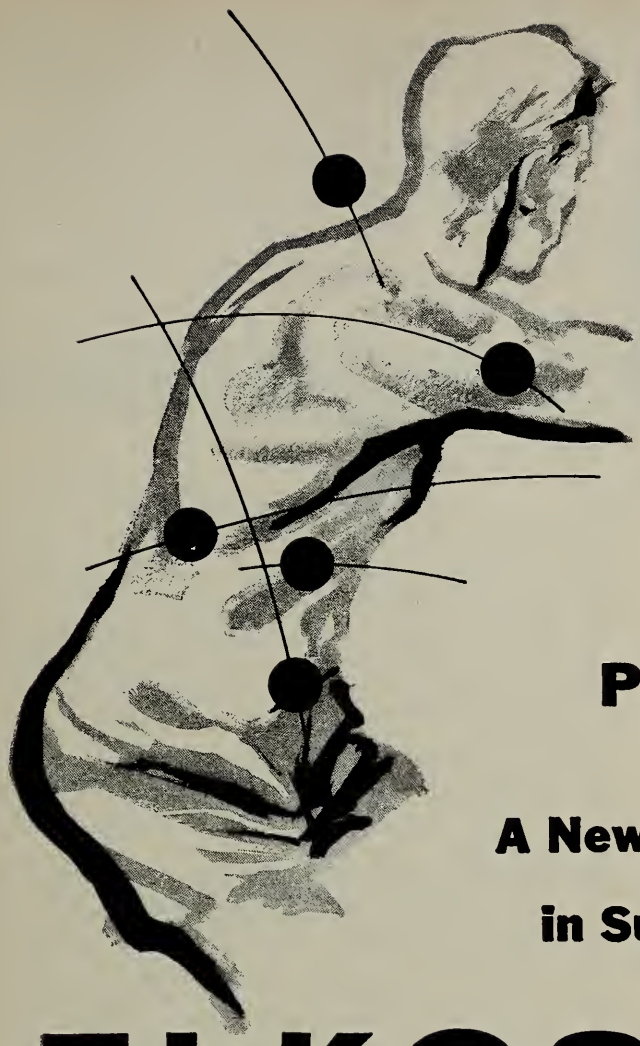
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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE LITERATURE ON STREPTOMYCIN, 1944-1952. By Selman A. Waksman. Rutgers University Press. New Brunswick, New Jersey, 1952. 553 pages. $5.00.

HOW TO HAVE A HAPPY CHILD. By Beulah France, R.N. Introduction by Milton Levine, M.D. Sterling Publishing Company Inc., New York. 130 pages. $2.50.

CONGENITAL ANOMALIES OF THE HEART AND GREAT VESSELS. By Maurice A. Schnitker, B.S., M.D., F.A.C.P., Lt. Col. A.U.S., Medical Consultant, Pacific Theater, World War II, Director of Medicine, St. Vincent's Hospital, Senior Active Staff, Toledo Hospital and Maumee Valley Hospital Consulting Staff, St. Luke's Hospital and Toledo State Hospital. Oxford University Press, New York, 1952. 306 pages. $8.00.

A CENTURY OF MEDICINE, 1848-1948. THE HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA. Edited by Howard Kistler Petry, M.D. 404 pages. $5.00.

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SURGERY AND THE ENDOCRINE SYSTEM — Physiologic Response to Surgical Trauma — Operative Management of Endocrine Dysfunction. By James D. Hardy, M.D., F.A.C.S., Assistant Professor of Surgery, University of Tennessee Medical College. 153 pages with 43 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $5.00.

HUMAN EMBRYOLOGY (Prenatal Development of Form and Function) by W. J. Hamilton, M.D., D.Sc., F.R.S.E., Professor of Anatomy in the University of London at Charing Cross Hospital Medical School, J. D. Boyd, M.A., M.Sc., M.D., Professor of Anatomy in the University of Cambridge and Fellow of Clare College, Cambridge, and H. W. Mossman, M.S., Ph.D., Associate Professor of Anatomy in the University of Wisconsin. The Williams & Wilkins Company, Baltimore. $9.00.

THE STORY OF CANCER FOR HIGH SCHOOLS. A manual for High School Science Classes. Part One — Facts About Cancer and Its Control. Part Two — Aids and Projects for Classroom Study. Prepared by the Cancer Control Committee of the Michigan State Medical Society, 1952.

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TREMORS

As a matter of convenience, tremors may be divided into three main groups: those associated with general physical disorders such as thyrotoxicosis, debilitated states, etc.; the arrythmic tremors commonly referred to as neostriatal in origin; and the rhythmic tremors presumably associated with pallidal disease. Although the mechanism of tremors is poorly understood, those occurring in patients of group one are favorably modified by treatment of the general physical disease. *Jefferson Browder, M.D. and Harry A. Kaplan, M.D. A Review Of The Medical And Surgical Treatment Of The Dyskinesiae. New York J. Med. Oct. 15, 1952.*

Tuberculosis is a personal tragedy and a community problem. It begins with the individual and must be fought in the individual and in his environment. Will Ross, former president of the NTA.

PERIANAL ABSCESS

Abscesses appearing in or near the anal canal usually originate in the region of the pectinate line and travel subcutaneously to rupture or be drained externally. These abscesses should be drained or uncapped as soon as the diagnosis is made to avoid further destruction of the sphincter muscle fibers and the supporting tissues. A wound which is large enough to remain open without packing is preferable to simple incision since it serves to terminate the spread of the infection more adequately. Linear incisions tend to close over rapidly and when this occurs, infection continues to spread. A large percentage of these abscesses terminate as perianal fistulas. It is always a good policy to advise the patient of this fact so that he will anticipate a second operation for fistula. Patients do not take to the second operaton kindly if they have been made to feel that the first operation did not accomplish the desired result. Except for the small abscess which is very fluctuant, the majority of these cases are best treated in the hospital where adequate anesthesia is available. *William C. Bernstein, M.D., Simple Protologic Procedures. Minnesota Med. Nov. 1952.*

Provision for individual patient instruction in the significance of asymptomatic tuberculosis lesions of small extent, or indeed of all inactive or suspected tuberculosis, is a great need which has grown out of mass survey examinations. This can be provided only by giving both clinic physicians and nurses the time to give each patient the full explanation he deserves. Howard M. Payne, M.D., Philip Enterline, and Julia Heuck, The Am. Review of TB, Nov., 1952.

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Vol. 103, No. 3 March, 1953

ILLINOIS PUBLIC AID COMMISSION MEDICAL CARE EXPENDITURES

The Executive Secretary of the Illinois Public Aid Commission has recently released a report showing the total medical care expenditures in Illinois for 1951, and for five months in 1952. For the past 12 years the Illinois State Medical Society has had a medical advisory committee to the Illinois Public Aid Commission, which holds a number of meetings each year with I. P. A. C. personnel to recommend policies and procedures relative to the operation of the Commission's medical care programs.

Many problems have arisen and have been given much consideration, and reports of the Medical Advisory Committee have been given regularly to the Society Council and annually to the House of Delegates. It is interesting to note that approximately 50% of the total medical care costs have been those pertaining to nursing home care.

One of the many functions of the Illinois State Department of Public Health has been the licensing of nursing homes, and through the activities of the State Department, many so called "fire traps" have been eliminated from this large list of nursing homes in Illinois. Formerly many were overcrowded, no fire protection was offered, and in some instances, the care given to the I. P. A. C. clients was definitely inadequate for the rates which were paid for care to the clients.

Under medical care in the report is included the amounts paid to physicians, dentists, hospitals, for nursing and housekeeping, for drugs, for ocular services and other medical care costs. A study of this report will show that of the total amount assessed as medical care expenditures, physicians actually receive approximately 20%.

TOTAL MEDICAL CARE EXPENDITURES
1951

TYPE OF CARE	ALL PROGRAMS
Total	$15,053,844.47
Nursing home care	7,511,361.82
Private nursing homes	4,922,541.11
County nursing homes	2,588,820.71
Medical Care	7,542,482.65
Physicians-Drugs	3,495,816.01
Hospital	2,654,144.79
Dental	173,630.19
Ocular	122,395.46
Nursing and Housekeeping	757,992.08
Other	338,504.12

PAYMENT FOR MEDICAL CARE FROM JUNE THROUGH OCTOBER 1952

TYPE OF CARE	ALL PROGRAMS
TOTAL	$9,999,438.75

Nursing Home Care	4,546,819.22
Medical Care	5,452,619.53
Physician	1,420,759.91
Drugs	907,104.70
Hospital	2,684,898.53
Other	439,856.39

Mr. Garrett W. Keaster, Executive Secretary of the Illinois Public Aid Commission, in submitting this report urges physicians who take care of public assistance recipients to submit their bills promptly and currently each month as there will be no chance to request a deficiency appropriation unless there is evidence that the funds appropriated by the legislature for the current biennium will be inadequate.

The Illinois Legislature is now in session, and the request of Mr. Keaster is quite important, and we hope that all physicians caring for public assistance recipients will not delay in submitting their bills for services to the Commission promptly each month.

POST GRADUATE CONFERENCE AT CAIRO

The first post graduate conference held in the Southern tip of Illinois was held at Cairo, Wednesday, January 28, 1953. The conference began at 1:00 P.M. in the new nurses home attached to St Mary's Hospital, with eleven speakers scheduled for the afternoon session. The speakers were all from Wesley Memorial Hospital, Chicago, and instructors at Northwestern University Medical School. For this conference, invitations and programs were sent to all physicians in the Southern end of Illinois, and those practicing in nearby points in Missouri and Kentucky.

The Alexander and Pulaski County Medical Societies made the necessary local arrangements and did everything possible to make the conference a successful one. There were 65 physicians registered for the afternoon session, and it was quite interesting to note that every physician practicing in Cairo, was present for the afternoon and evening sessions. Arrangements had been to entertain visiting ladies at the Manor House, headquarters for General U. S. Grant while in Cairo during the Civil War.

The evening session was held at Hotel Cairo in a fine private dining room, and there were more than 60 present for the dinner and evening meeting. With the relatively few physicians in this area, physicians were present from more than twenty counties, a number coming more than 100 miles to attend the conference.

The officers of the Alexander and Pulaski County Societies deserve much credit for the success of this conference, and the fine attendance for the entire session. Although in some more populous areas in Illinois from 100 to 250 physicians have been registered at the post graduate conferences, the one at Cairo was outstanding both in attendance and in the interest shown by all who were present. Dr. Hellmuth, as Chairman of the State Society Committee on Postgraduate Education likewise deserves much credit for the fine array of speakers who were scheduled, and for the decision this year to schedule conferences in parts of Illinois which have not previously been given this service.

DOCTORS FOR RURAL COMMUNITIES

Many people remember when every country town had one or more physicians to care for them in time of illness. We did not have today's system of hard roads, and the many secondary all weather roads and the doctor had to travel rural roads which part of the year were almost impassable.

Today it is becoming more difficult to get physicians to locate in small towns, and for many reasons. With the system of good roads, modern methods of travel, and realizing that too many small towns do not have more than elementary schools, physicians, being human prefer locations where better living conditions are available.

During World War II it became our duty as state Chairman for the Warmanpower Commission Procurement and Assignment Service for Physicians to not only aid in the determination as to whether certain physicians were available for military service, or should be held as essential for care of those in the community, but we had the responsibility of aiding in relocation problems when something happened to those older physicians carrying the unusually heavy load of medical care.

Some interesting problems confronted us, and

we were able to find elderly physicians in the city who had retired, or were doing limited work, who thought it their patriotic duty to go into small communities and become country doctors for the duration. These rural communities invariably went all out to help the doctor and show their appreciation for his efforts in many ways.

With the constantly increasing number of hospital beds even in rural communities, there are but few areas in this midwestern section where hospitals cannot be reached within a short period of time from the site of accident or illness. However, there are many small towns which can support a physician, make a good home and office available, with good schools and churches, so that he can enjoy the benefits of modern living.

Our State Medical Societies, after the ending of the Procurement and Assignment Service, were asked to carry on by developing our own physicians' placement services. Realizing the difficulty of getting physicians to locate in many small towns, it was suggested that the community show its determination and willingness to cooperate in the venture, by making a fund available, from which the physician could draw to aid in fitting his office, establishing a home, and making the first payments on the necessary automobile.

Several communities tried this method, and one reported that they had accumulated a fund of several thousand dollars for the purpose. Within a few weeks we were able to send a well qualified young physician into the community, and after a period of two years he was able to repay the loan. He has a very good practice, a modern home and office, and he and his family are well received in the community. Several other communities to our knowledge have tried this method and it has worked out well indeed.

Before recommending physicians to communities in the rural areas needing physicians we get information from both the physician and the community, so that we may be sure that it will not be a case of a square peg in a round hole. The physician needs information relative to the community and what it has to offer and the community must be sure that the doctor will be satisfied, that he is well qualified and willing to become a part of the community itself.

We likewise must be sure today of the military status of the younger physicians, as too often one of these younger men will locate and build up a good practice, then find that he must become a part of the military medical corps for a period of not less than two years. Even though a community in the rural areas had two physicians 25 years ago, and perhaps three or four fifty years ago, it does not mean that a physician will prosper there today. A complete evaluation of the actual situation is necessary, what they have to offer, the number of people in the immediate trade area, then what will they be willing to do to help the physician get properly started on his professional career.

CITIZENSHIP A REQUIREMENT FOR MEDICAL SOCIETY MEMBERSHIP

Unlike a number of states, Illinois permits the licensure of physicians able to pass the necessary tests, provided they have taken out first papers and have had a one year rotating internship in a Illinois hospital. However, they must produce evidence to show that they are graduates of medical schools which meets the requirements of the State Department of Registration and Education.

This makes an unfortunate situation in Illinois, for the By-Laws of the Illinois State Medical Society specifically state that candidates for membership must be American citizens. One of our neighboring states, Iowa, makes citizenship a requirement for licensure, and we are informed they are having protests from members of the public and by the press at this ruling.

There are a considerable number of physicians now licensed in Illinois who have not acquired their citizenship, many of them doing a fine job in their professional work, and protests have been received by the State Medical Society because of their inability of becoming members of organized medicine. From information available, we are inclined to believe that citizenship is a requirement in most other countries, and a number of American physicians going to European countries have had this problem to contend with.

In Illinois election to membership in the county medical society automatically gives membership in the State Medical Society and the American Medical Association. It is not per-

missible, therefore, to hold membership in the county society alone. This is a question frequently asked by physicians who believe they should become members of a county society even though not eligible for membership in the state society.

As soon as licensed physicians acquire full citizenship, they are eligible for membership in our medical organizations, the county society, state society and the A. M. A.

THE ILLINOIS HEALTH IMPROVEMENT ASSOCIATION

The Health Impovement Association movement was initiated by the Chicago Blue Cross Plan in 1948 to form residents of rural areas, by counties, into groups which would be eligible for Blue Cross hospital insurance. When Blue Shield medical insurance became available, it was added to the benefits.

The first association formed was in McLean County. In 1951 presidents of all associations met for a conference in Peoria. The second presidents' conference in 1952 voted to establish the Illinois Health Improvement Association. January 15 and 16, 1953, the Illinois Health Improvement Association held its first annual meeting and third presidents' conference in Decatur, with representatives of 69 county associations, covering 72 of the 101 down state counties, in attendance.

This is a brief report of that meeting, prepared to bring the Society up to date concerning the widespread, dynamic and highly important work of the health improvement associations in Illinois. Statistics are unsatisfactory, because the organizations are growing so rapidly that any figures quickly become obsolete, while some of the groups have been in operation only a short time. However, as of September 30, 1952, the 69 associations had about 132,000 members under Blue Cross and about 65,000 under Blue Shield. Blue Cross had paid $2,456,000 in benefits. Blue Shield, in effect on that date in only 26 counties, most of them only for a few weeks, had paid $137,790.

The organization campaign is being pressed vigorously throughout the state, except in the Rock Island and Rockford areas. In Kendall County 800 of 1100 potential members have been enrolled. Two regional offices are maintained at Peoria and Centralia, each with responsibility for three districts. The area around Chicago is a seventh separate district. It is expected the organization of all possible counties will be completed this year.

Each county member pays dues of $2 a year, in addition to his Blue Cross and Blue Shield premiums. Counties pay dues of 10 cents a year per member as of Jan. 1 to the state association. Enrollment drives for new members are held every year. Each association has the usual officers, with a treasurer who is bonded in most cases, and maintains a suitable office, with permanent employees who are responsible for proper records.

The state association consists of delegates from each county association. Its officers, re-elected for a year at the Decatur meeting, are: H. P. Ash of Harristown, Macon County, president; Wallace Harris of Macomb, McDonough County, vice-president; and Mrs. Mildred Kenniston of Manhattan, Will County, secretary-treasurer. The meeting elected a board of directors composed of one representative from each of the seven districts, plus the officers.

One of the more significant facts about the H. I. A. movement is that each county group, in addition to its Blue Cross and Blue Shield programs, may also serve as a local health council, to study its own health problems and take organized action to correct deficiencies. The establishment of such county health councils has for several years been part of the long-range public relations program of the Illinois State Medical Society but those formed usually centered around a single pressing issue and dwindled away after the issue was resolved.

However, with the permanent voluntary insurance program to act as a continuing cohesive force, permanent long-range health programs become possible. The fact that the county farm and home bureaus are actively cooperating with the health improvement associations gives these programs additional impetus.

Most of those present, in response to a call for a show of hands, said that they were also receiving good cooperation from the medical societies of their counties. A few hands were raised to indicate unsatisfactory relationships. These latter were invited to communicate with the state society. One speaker, a physician,

noted an apparent failure of cooperation on the part of the state health department.

Talks given during the meeting indicated a wide range of health improvement activities on the part of the various groups. At least twenty, for instance, support scholarships to finance the training of local girls as nurses. They pay tuition and provide monthly spending money. Most of them take a hand in student nurse recruitment campaigns. Other activities include: Support of cancer, poliomyelitis, heart and other fund-raising and public education drives; blood collection; general health education in rural areas; provision of prizes to 4H Clubs for best health work; agitation for clean potable water supplies; study of fluoridation of water supplies; agitation for testing of dairy herds and other farm animals for tuberculosis and brucellosis; campaign to establish some one trained in first aid in every farm home; and others.

Other activities suggested by various speakers were agitation for establishment of county health departments where none yet exists; a drive for more state funds for veterinary research and education; support of state and local health legislation; cooperation with other groups in establishing and executing programs; highway safety programs; supplying funds to permit local teachers to attend summer workshops on rural health education.

Obviously, a vigorous, numerous, self-reliant and well-led organization such as the health improvement group, working in the hospital and medical care insurance field and in general health programs, deserves the continuing serious interest, and the cooperation as circumstances indicate, of organized medicine. Most of those approached voice appreciation of the help so far given by medical societies. County society officers might well give thought to the possibility of providing in each county a permanent advisory committee where none exists, to help county health improvement association in planning and working out local health programs. They are on medicine's side unquestionably in the battle against socialism, they are providing voluntary pre-payment insurance, they are seeking to improve their own health environment — all of which are medicine's own objectives.

The two guest speakers at the meeting were Robert Graham, D.V.M., dean of the School of Veterinary Medicine at the University of Illinois; and Paul G. Johnson, Chicago, editor of The Prairie Farmer. Mr. Johnson called attention of the group to several major health issues such as mental hygiene and geriatrics which he urged them to study.

Dean Graham outlined a number of animal health problems which also involve human beings. He revealed the unpublished fact that leptospirosis, a spirochetal infection which also affects human and dogs, has been present in cattle, sheep and swine in Illinois since 1947. It was brought here by Texas cattle. No cases in human beings have yet been traced to the affected animals in Illinois, but he warned physicians in rural areas to be on the alert for it.

James C. Leary
Director of
Public Relations

PERIODIC HEALTH EXAMINATIONS

About 25 years ago efforts were made throughout the nation to get people apparently well to have an annual check-up by their family physician. Since that time many people have had these physical check-ups at a time usually of their own selection. It is unfortunate that patients are rarely seen by their physician at the onset of their disease, as most of them wait until they are really sick before seeking medical attention.

Statistics released from the office of the Surgeon General of the United States Public Health Service show that each year approximately 78% of all deaths are attributed to chronic disease. About 25% of these deaths are from diseases which are considered detectable. Chronic disease remains one of the big problems confronting the medical profession, and it has been shown by industrial surveys that approximately 90% of the absenteeism is due to non-occupational illness and accidents.

In the continued efforts to improve mortality and morbidity statistics from the chronic diseases, the earliest possible detection is perhaps the most important factor. If detected relatively early it may be possible to check the extension of the disease, to minimize many of the complications which almost invariably follow. Complete treatment services must be instituted, then efforts should be made to institute rehabilitation

services to compensate for existing handicaps.

During the past five years much information has been procured through multiphasic screening programs in various parts of the country. Through the cooperation of health departments, medical societies, hospitals and other interested agencies thousands of apparently well people have been given to designated personal physicians for additional check-ups, and many chronic ailments have been discovered.

It has long been known that the problem of chronic illness is a challenge to the medical profession, and it is of much concern to industry, business, and social agencies. Many of those having chronic diseases ultimately become clients of the public aid agencies as their earning ability has waned.

One factor which has been publicized through the operation of multiphasic screening programs conducted as an experiment, is the relatively low cost. In one of these programs it was stated that the total cost per person for the complete service was $10.04, this including the physical examinations, the screening tests, salaries of all personnel including the follow-up by the family physician, and all supplies and rent. It was also found, that many people going to the clinic to receive the service would not have gone to a private physician until their symptoms were well advanced.

In elderly people the early detection of chronic illness may mean the difference between reclining years of suffering and a few more years of pleasure, relaxation and attention to personal hobbies. Likewise it could be a factor in reducing the number of public aid clients with the saving of public funds.

Many hospitals today get a chest film of every patient admitted to the institution without any cost to the patient. Many cases of tuberculosis, as well as other pulmonary ailments have been detected through this procedure. Educating the public to ask for adequate periodic health examinations is a difficult procedure and it will no doubt require the aid of many organizations and groups outside of the medical profession to achieve this objective.

It remains a problem in education and efforts should be continuously made to publicize the advantages of detecting disease in the apparently well, at a time when something can be done to check the diseased process.

TUBERCULOSIS SHOULD BE CONQUERED

Dr. Louis I. Dublin, statistician for the Metropolitan Life Insurance Company, recently stated that tuberculosis took only one-third as many lives in the United States in 1952, as it did twenty years ago. During this 20 year period the population of this country has increased approximately 25%. This is an encouraging report, yet much more can be done to further eliminate the dangers of this dreaded disease, and perhaps eventually exterminate it completely.

Dr. Dublin estimates that there are now 1,200,000 cases of tuberculosis in the United States, and 400,000 of these remain active. About 250,000 of these are outside of hospitals and sanatoria, and of these, 150,000 are either undiagnosed or unreported. These people are chiefly responsible for the spread of the disease. A continuous process of education and investigation remains in order, if we hope to improve the statistics from this point.

Many hospitals today in the United States get a chest x-ray on every patient admitted and usually at no cost to the patient. Many new cases are detected by this procedure and it is one which should be adopted more generally throughout the nation. For many years the cause of tuberculosis has been known, and throughout this period, methods of treatment have been improved so greatly that when diagnosed early its ravages should be completely checked.

Early diagnosis is the first requisite in the program, and a proper understanding on the part of physician and patient of the fundamental characteristics of the disease, and what can be done for it, are essential. Then proper preventive and therapeutic measures must be instituted. People should be continuously told of its mode of spread, the necessity for proper care and of course the way it is spread.

Then the period of rehabilitation, and the necessity for continuous medical supervision to be sure that the process does not become reactivated. There is much to be done if we hope to eventually overcome the ravages of one of the greatest killers among diseases throughout the ages. With the proper application of the knowledge now available the disease should be conquered, although it will require much effort for it cannot be accomplished in a short time.

PRELIMINARY PROGRAM
of the
ILLINOIS STATE MEDICAL SOCIETY
ANNUAL MEETING

Hotel Sherman
CHICAGO, ILLINOIS
May 19, 20, 21, 22, 1953

General Assemblies

Wednesday Afternoon, May 20, 1953
The Ballroom

Presiding **Harry H. Boyle,** Chicago
Assisting **Earl H. Merz,** Chicago

1:20—Opening of the General Assembly
Leo P. A. Sweeney, President, Chicago

1:30—**M. G. Peterman,** Milwaukee, Wisconsin
"The Treatment of Convulsions in Childhood"

2:00—President's Address — **Leo P. A. Sweeney,** Chicago

2:30—**Lester R. Dragstedt,** Professor and Chairman of Department of Surgery, University of Chicago, Chicago
"The Present Status of Vagotomy"

2:50—RECESS to view exhibits

Presiding **Hugh A. Flack,** Chicago
Assisting **A. R. K. Matthews,** Rockford

3:20—**Herbert Rattner,** Chairman, Department of Dermatology, Northwestern University Medical School
"The New in Dermatology"

3:40—**A. Carlton Ernstene,** Chief of Staff, Cleveland, Ohio
"Management of Cardiac Patients in Relation to Surgery"

4:10—**Harold F. Falls,** Professor of Ophthalmology, University of Michigan, Ann Arbor, Michigan
"Ocular Manifestations of Constitutional Disease"

4:40—**William Becker,** Clinical Professor of Dermatology, University of Chicago Clinics, Chicago
"Diagnosis and Treatment of Pigmented Moles and Melanomas"

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Thursday Morning, May 21, 1953
Ballroom

Presiding **Arkell M. Vaughn,** Chicago
Assisting **Hubert L. Allen,** Alton

9:00—**Rachmiel Levine,** Chairman, Department of Medicine, Michael Reese Hospital, Chicago
"The Physiological Basis for the Use of ACTH and Cortisone in Allergic States"

9:20—

9:50—ORATION IN SURGERY: **Charles S. Stevenson,** Department of Obstetrics and Gynecology, Wayne University School of Medicine, Detroit, Michigan
"The Diagnosis of Occult Ectopic Pregnancy"

10:35—RECESS to view exhibits

Presiding **Franklin J. Moore,** Chicago
Assisting **Morris A. Kaplan,** Chicago

11:00—**J. Harvey Black,** Professor of Medicine, Southwestern Medical School of the University of Texas, Dallas, Texas

11:30—**John P. Wyatt,** Professor of Pathology, St. Louis University School of Medicine, St. Louis, Missouri
"Current Trends in Viral Disease"

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Thursday Afternoon, May 21, 1953
Ballroom

Presiding **Charles F. Sutton,** Springfield
Assisting **Jerome M. Brosnan,** Chicago

1:30—**B. Marden Black,** Mayo Clinic, Rochester, Minnesota
"The Management of Acute Intestinal Obstruction"

2:00—**Roland R. Cross,** Director, Illinois Department of Public Health, Springfield
"Looking Ahead in Public Health"

2:20—**ORATION IN MEDICINE: Perrin H. Long,** Professor of Preventive Medicine, Johns Hopkins University School of Medicine, Baltimore

3:05—RECESS to view exhibits

Presiding **James B. Gillespie,** Urbana
Assisting **Malcolm Spencer,** Danville

3:30—**Alan R. Moritz,** Professer of Pathology and Director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio
"Coroner Versus Medical Examiner"

4:00—**Paul A. O'Leary,** Chief, Section on Dermatology, Mayo Clinic, Rochester, Minnesota
"Dermatologic Emergencies Seen in General Practice"

4:30—**John R. Hodgson,** Mayo Clinic, Rochester, Minnesota
"What Can the Radiologist Contribute to the Diagnosis of Gastro-Intestinal Disease in Children"

Friday Morning, May 22, 1953
Ballroom

Presiding **Walter H. Baer,** Springfield
Assisting **William F. Hubble,** Decatur

9:00—**O. E. VanAlyea,** Clinical Professor, Otolaryngology, University of Illinois College of Medicine, Chicago
"Recent Advances in Treatment of Sinus Disease."

9:20—**Leo H. Bartemeier,** Chairman of the Mental Health Committee, American Medical Association; Past President, American Psychiatric Association, Associate Professor of Psychiatry, Wayne University School of Medicine, Detroit, Michigan
"Contributions from Psychiatry to the General Practice of Medicine"

9:50—**V. Thomas Austin,** President, Illinois Heart Association, Urbana
"Coronary Heart Disease"

10:10—RECESS to view exhibits

SYMPOSIUM—"Post-Operative Care of the Patient"

Moderator **J. C. Thomas Rogers,** Urbana

10:40—**Warren Cole,** University of Illinois — Chairman, Department of Surgery

10:55—**Smith Freeman,** Northwestern University Medical School

11:10—**John H. Gilmore,** Roentgenologist, Illinois Masonic Hospital

11:25—**Laurence Ruttle,** Joliet

11:40-12:00—Question and Answer Period

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Friday Afternoon, May 22, 1953
Ballroom

Presiding **Wright Adams,** Chicago

1:30—**Emmanuel Papper,** Director of Anesthesia Service, Presbyterian Hospital, New York City.
"Acid Base Balance"

SYMPOSIUM—"Fetal Death—Its Prevention"

2:00—**Frederick H. Falls,** Chicago

2:15—**Paul Searles**

2:30—**Julius Richmond,** Chicago

2:45—

3:00—Question and Answer Period

3:15—Adjournment

The House of Delegates

The First Meeting of the House of Delegates will be held on Tuesday afternoon, May 19, at 3:00 o'clock, in the Louis XVI Room. The meeting will be called to order by the President for the

(1) Reports of Officers, Councilors, Committees,
(2) Appointment of Reference Committees
(3) Introduction of Resolutions,

and for the transaction of other business which may come before the House. At this meeting, all matters are referred to the various Reference Committees which will meet on Wednesday morning and afternoon. The members of the Reference Committees will be announced and the places and time of the meetings will be scheduled. Any physician attending the annual meeting is privileged to appear before these committees to discuss any matter under consideration. Following the open hearing, the Committee will go into executive session to prepare the report to the House. Reports will be made at the second and third meetings of the House as follows:

SECOND MEETING OF THE HOUSE OF DELEGATES will be held Thursday Afternoon, May 21, in Parlors L, M, and O on the Mezzanine Floor at 3:00 o'clock to hear those reports which are ready to be presented.

THE THIRD MEETING OF THE HOUSE OF DELEGATES will be held Friday morning, May 22, at 8:30 a.m. in Parlors L M and O on the Mezzanine Floor to hear those reports remaining to be presented, and for the election of officers, Councilors, Committees, Delegates and Alternates to the American Medical Association, and to transact any other business to come before the House.

At the close of this meeting, Dr. Willis I. Lewis of Herrin will be installed as the new President of the Illinois State Medical Society. He will receive the official gavel from the retiring President, Leo P. A. Sweeney of Chicago.

Section Programs

SECTION ON ANESTHESIOLOGY

Chairman **James A. Felts,** Marion
Secretary **Max S. Sadove,** Chicago

Tuesday Morning, May 19
Room 103

●

SECTION ON CARDIOVASCULAR DISEASE

Chairman **James A. Walsh,** Peoria
Secretary **Wright Adams,** Chicago

Tuesday Morning, May 19
Parlor "L"

9:00—**Harl W. Matheson,** Peoria
"The Management of Cardio-Pulmonary Failure in Kyphoscoliosis"

9:20—**Louis B. Newman,** Chief, Physical Medicine and Rehabilitation, Hines Veterans Administration Hospital
"Rehabilitation of Cardiacs"

9:40—**Robert L. Grissom,** Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago
"Indications for Mitral Valvulotomy"

10:00—RECESS to view exhibits

10:30—**A. Carlton Ernstene,** Chief of Staff, Division of Medicine, Cleveland Clinic, Cleveland, Ohio
"Complications and Sequelae of Acute Myocardial Infarction"

11:00—**Chauncey C. Maher,** Associate Professor of Medicine, Northwestern University Medical School, Chicago
"Cardiac Arrhythmias"

11:20—**Emmet F. Pearson,** Springfield
"Some Effects of Chronic Pulmonary Disease on the Circulation, and New Concepts of Treatment"

11:40—Question and Answer Period
Doctors Matheson, Newman, Grissom, Ernstene, Maher and Pearson

●

SECTION ON PATHOLOGY

Chairman **A. R. K. Matthews,** Rockford
Secretary **Franklin J. Moore,** Chicago

Tuesday Morning, May 19
Parlor "M"

SECTION ON EYE, EAR, NOSE AND THROAT

Chairman **William F. Hubble,** Decatur
Secretary **Earl H. Merz,** Chicago

Tuesday Morning, May 19, 1953
Parlor "O"

9:00—**Robert W. Lennon,** Joliet
"Pharmacology of the Pupil with Practical Consideration"

9:20—**Robert Henner,** Chicago
"Bone Conduction Studies after Fenestration Surgery and Predictions of Hearing Results"

9:40—**Irving Puntenney,** Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago
"The Principles of the Cross Cylinder and Its Uses in Refraction"

10:00—**Maurice F. Snitman,** Consultant, Tumor Section, Veterans Administration Hospital, Hines; Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago
"Surgery of Carcinoma of the Pharynx"
Co-author, **Irwin D. Horwitz,** Clinical Assistant Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

10:20—**Harold F. Falls,** Professor of Ophthalmology, University of Michigan College of Medicine, Ann Arbor, Michigan
"Recently Recognized Syndromes Having Ocular Association"

11:05—Business Meeting

11:20—RECESS to view exhibits

Tuesday Afternoon, May 19, 1953
Parlor "O"

1:30—**John L. Feldman,** Chief, Department of Otolaryngology, Quincy Clinic
"The Treatment of Typical and Atypical Facial Neuralgias"

1:50—**James Wilson Clark,** Associate Clinical Professor of Ophthalmology, University of Illinois College of Medicine; Senior Attending, Staff, St. Luke's Hospital, Chicago
"Treatment of Lacrimal Obstruction"

2:10—**Paul H. Holinger,** Professor of Otolaryngology, University of Illinois College of Medicine, Chicago
"Corrosive Esophagitis"
Co-authors: **Marvin J. Tamari, Stanley H. Bear**

2:30—**Max Hirschfelder,** Attending Oculist, St. Mary's Hospital, Centralia
"Ophthalmology in Rural Areas"

2:50—RECESS to view exhibits

3:20—**Pierce W. Theobald,** Chicago
"Diagnosis and Treatment of Secretory Otitis Media"

3:40—**Beulah Cushman,** Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago
"Accommodation and Its Relation to Problems in Ocular Motility"
Co-author: **Devereaux Jarratt,** Department of Ophthalmology, Northwestern University Medical School, Chicago

4:00—**Paul C. Irvine,** Chicago
"Corneal Injuries"

4:20—**Eugene L. Derlacki,** Senior Attending Staff, Wesley Memorial Hospital; Associate, Department of Otolaryngology, Northwestern University Medical School
"Correction of Congenital Anomalies of the Ear"

●

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Chairman **Charles F. Sutton,** Springfield
Secretary **Leroy L. Fatherree,** Joliet

The Section on Preventive Medicine and Public Health will have a luncheon at 12:00 noon on Tuesday, May 19, in the Gold Room (Room 114) on the First Floor of the Hotel Sherman.

Tuesday Afternoon, May 19, 1953
Room 114

2:00—**Norman J. Rose,** Chief, Bureau of Epidemiology, Illinois Department of Public Health, Springfield
"Changes in the Rules and Regulations for the Control of Communicable Diseases"
Questions and Discussion

2:50—RECESS to view exhibits

3:20—**Harry F. Dowling,** Professor of Medicine and Head of Department of Medicine, University of Illinois College of Medicine, Chicago
"Current Status of Gamma Globulin and Vaccines as Immunizing Agents for Poliomyelitis"
Questions and Discussion

4:00—**Felix A. Tornabene,** Health Officer, Northeastern Region, Illinois Department of Public Health, Aurora
"Differential Diagnosis of Poliomyelitis"
Questions and Discussion

4:30—Business Meeting

●

SECTION ON RADIOLOGY

Chairman **Jerome M. Brosman,** Chicago
Secretary **George Irwin, Jr.,** Bloomington

Tuesday Afternoon, May 19, 1953
Room 104

3:30 p.m. The guest moderator of the Section on Radiology, will be Dr. John R. Hodgson, Rochester, Minn. A film reading session will be held and all physicians interested will be most welcome. Doctor Hodgson will also speak before the General Assembly on Thursday afternoon.

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SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman **Hubert L. Allen,** Alton
Secretary **James P. FitzGibbons,** Chicago

Tuesday Afternoon, May 19, 1953
Parlor "L"

●

SECTION ON DERMATOLOGY

Chairman **Malcolm Spencer,** Decatur

Wednesday Morning, May 20, 1953
Parlor "L"

Papers — 10 minutes
Discussion — 5 minutes

9:00—**Introductory Remarks by Temporary Chairman, Malcolm C. Spencer,** Danville
"History of Dermatology in Illinois"
Samuel J. Zakon, Chicago
Discussant: **John M. McCuskey,** Peoria

"Acne, Some Recent Concepts of Etiology and Management"
J. William Didcoct, Urbana
Discussant: **Louis Rubin,** Rockford
"Re-evaluation of Hemangiomas"
Albert H. Slepyan, Highland Park
Discussant: **Theodore Cornbleet,** Chicago
"The Psoriasis Problem"
Hans Buley, Champaign
Discussant: **Wilton Robin,** Chicago
"Non-Specific Cutaneous Manifestations of the Lymphomas and Internal Cancer"
Samuel M. Bluefarb, Chicago
Discussant: **Julius Ginsberg,** Chicago
"The Effect of Selenium on the Understanding and Management of Seborrhea"
William N. Slinger, Rockford
Discussant: **Hilliard M. Shair,** Quincy
"Resistant Superficial Fungus Infections — Clinical Evaluation and Management"
Allan L. Lorincz, Chicago
Discussant: **Isaac M. Felsher,** Chicago
"Recent Dermatologic Hazards in Industry"
Leonard Weber, Chicago
Discussant: **Frederick Szymanski,** Chicago

SECTION ON PEDIATRICS

Chairman **Harry H. Boyle,** Chicago
Secretary **James B. Gillespie,** Urbana

Wednesday Morning, May 20, 1953
Louis XVI Room
SYMPOSIUM

"The Uses and Abuses of Chemotherapeutic and Antibiotic Agents for Infections in Children"

9:00—**L. Martin Hardy,** Children's Memorial Hospital, Chicago
"Uncomplicated Upper Respiratory Infections in Children and the Promiscuous Use of Chemotherapeutic Agents"

9:30—**Howard S. Traisman,** Children's Memorial Hospital, Chicago
"Review of the Literature and a Preliminary Report on a Controlled Study in the Uses of Chemotherapeutic and Antibiotic Agents in Uncomplicated Upper Respiratory Infections in Children"

9:50—**Paul P. Pierce,** Alton
"Chemotherapeutic and Antibiotic Agents in the Treatment of Complications of Upper Respiratory Infections in Children"

10:10—RECESS to view exhibits

10:40—**Walter M. Whitaker,** Quincy
"Chemotherapeutic and Antibiotic Agents in the Treatment of Meningitides and Gastro-Intestinal Infections in Children"

11:00—**James S. Walker,** Carle Memorial Hospital, Urbana
"The Failure of Antibiotic and Chemotherapeutic Agents Because of Neglected Basic Principles in the Treatment of Otolaryngologic Infections"

11:20—**Don E. Murray,** St. Luke's Hospital, Chicago
"Chemotherapeutic and Antibiotic Agents in the Treatment of Genito-Urinary Infections in Children"

11:40—Questions and Discussion

The Illinois Chapter, American Academy of Pediatrics will have a luncheon in the Louis XVI Room at which all physicians interested, may attend.

1:30—**M. G. Peterman,** Milwaukee
"The Treatment of Convulsions in Childhood"

SECTION ON ALLERGY

Chairman **Harry L. Huber,** Chicago
Secretary **Morris A. Kaplan,** Chicago

Wednesday Morning, May 20, 1953
Parlor "M"

9:00—**Ben Z. Rappaport,** Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago
"Allergy in General Practice"

9:20—**Morris A. Kaplan,** Assistant Professor of Medicine, Chicago Medical School, Chicago
"Diagnostic Methods"

9:40—**Ellis A. Canterbury,** Peoria
"Allergic Rhinitis"

10:00—**Leon Unger,** Attending Physician, Cook County and Wesley Memorial Hospitals, Chicago
"Bronchial Asthma"

10:20—RECESS to view exhibits

10:40—**M. R. Lichtenstein,** Acting Medical Director, Municipal Tuberculosis Sanitorium
Leroy H. Berard, Assistant Chief of Medical Service, Municipal Tuberculosis Sanitorium
"Differential Diagnosis of Pulmonary Conditions"

11:00—**Townsend B. Friedman,** Chairman, Department of Allergy, Children's Memorial Hospital, Michael Reese Hospital, Chicago
"The Allergic Cripple"

11:20—**James R. Webster,** Professor of Dermatology, Northwestern University Medical School, Chicago
"Dermatology in Allergy"

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SECTION ON SURGERY

Chairman **J. C. Thomas Rogers,** Urbana
Secretary **Arkell M. Vaughn,** Chicago

Wednesday Morning, May 20, 1953
Parlor "O"

9:00—**Louis D. Whittaker,** Peoria
"Obscure Gastro-intestinal Bleeding"

9:15—**Leo Zimmerman,** Professor of Surgery and Co-Chairman, Department of Surgery, Chicago Medical School, Chicago
David H. Wagner, Chicago
"Carcinoma of Thyroid and Its Relation to Nodular Goiter"

9:30—**Armand D. Albrecht,** Champaign
"Surgery of the Aged"

9:45—**Manuel Lichenstein,** Professor of Surgery, Cook County Graduate School of Medicine, and Associate Professor of Surgery, Northwestern University Medical School, Chicago
"Anatomic Dangers in Gallbladder Surgery"

10:00—**Charles Z. Baldrea, Jr.,** Belleville
"Acute Pancreatitis"

10:15—**Harry Oberhelman,** Professor and Chairman, Department of Surgery, Stritch School of Medicine, Loyola University, Chicago
"Benign Lesions of the Small Intestines"

10:30—**Gordon F. Moore,** Alton
"Surgical Lesions of the Breast"

10:45—**William M. Lees,** Chief Surgeon, Municipal Tuberculosis Sanitarium, Clinical Assistant Professor of Surgery, Stritch School of Medicine, Loyola University, Chicago
"Differential Diagnosis of X-Ray Shadows in the Chest"

You'll Not Want To Miss This Program!

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A. S. Aloe Company, St. Louis
American Hospital Supply Corp., Evanston
Arnar-Stone Laboratories, Inc., Evanston
Armour Laboratories, Chicago
Ayerst, McKenna & Harrison, New York

Baby Development Clinic, Chicago
Baker Laboratories, Inc., Cleveland
Bilhuber-Knoll Corp., Orange, New Jersey
Blue Cross Plan for Hospital Care, Chicago
Brown and Williamson Tobacco Corp., Louisville, Ky.

Camel Cigarettes, New York
Chicago Pharmacal Company, Chicago
Ciba Pharmaceutical Products Co., Summit, New Jersey
Coca Cola Company, Atlanta, Georgia

Daniels Surgical & Medical Supplies, Chicago
Doho Chemical Corp., New York
Dayless Mfg. Co., Inc., Chicago
Doak Company, Cleveland

Eisele and Company, Nashville, Tenn.
Eli Lilly & Company, Indianapolis
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H. G. Fischer & Co., Franklin Park, Ill.

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Mead Johnson & Co., Evansville, Ind.
Medco Products Company, Tulsa, Okla.
Medical Aids, Inc., Chicago
Medical Arts Supply Co., Chicago
The Medical Protective Co., Fort Wayne, Ind.
Miller Surgical Co., Chicago
C. V. Mosby Company, St. Louis
M & R Laboratories Inc., Columbus, Ohio
V. Mueller and Co., Chicago

The National Drug Co., Philadelphia, Pa.
Nepera Chemical Co., Inc., Yonkers, N. Y.

Parke, Davis & Co., Detroit
Charles Pfizer and Co., Inc., Brooklyn, N. Y.
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A. R. Robins Co., Richmond, Va.
J. B. Roerig and Co., Chicago

Sanborn Company, Cambridge, Mass.
Sandoz Chemical Works, Inc., New York
W. B. Saunders Co., Philadelphia
Schering Corp., Bloomfield, N. J.
G. D. Searle & Co., Chicago
Smith, Kline and French Laboratories, Philadelphia
E. R. Squibb and Sons, New York
The Stuart Company, Chicago
Julius Schmid, Inc., New York
Sherman Laboratories, Detroit

Tattle Toes Co., Chesterfield, Mo.
Travenol Laboratories, Inc., Morton Grove

The Upjohn Company, Kalamazoo, Michigan
U. S. Vitamin Corp., New York

Varick Pharmacal Company, New York

Winthrop-Stearns, Inc., New York
Westinghouse Electric Corp., Baltimore, Maryland

F. E. Young and Co., Chicago

The Zemmer Co., Pittsburgh, Pa.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Please, Doctor, Your Rhetoric

W. W. Fullerton, M.D.
Steeleville

We appreciate the assistance the insurance companies have given in our fight and vigilance against socialized medicine, particularly the compulsory federal brand. We have welcomed the willingness and the activity the insurance companies have given us in following up our ideas on prepaid voluntary medical insurance plans: and more or less the companies as a whole have been active in support of our fight against federal socialization.

We are going to discuss in this article the complex and varied forms which are issued by various insurance companies throughout the country; which they have developed for use by the medical profession, in order that they may secure the information they desire from the examining physicians. This, in some respects, may be a little bit remote from the field of economics, but is not particularly remote when you realize that it is a matter of economy of time involved in filling out these forms, and not only a matter of saving time for the doctor, but for the applicants being examined, and the time that such examinations may take from our other patients. The problem, in this respect, falls within the realm of medical economics. We believe, in this particular realm, that it may be to the economy of the insurance company to have direct, explicit, and simple answers.

However, we are reminded a little bit of the certain pot-luck supper which was once held, in which everyone was to bring some portion of food, and everyone, of course, showed up with the customary potato salad bowl, leaving a pronouncedly unbalanced meal. The insurance companies each have their own peculiarities, as maybe they should, because certain medical directors of the companies have their own particular type of form and develop their own system of examination and forms for getting information. Compensation companies have their own peculiar ideas as to what they want to know about certain injuries. Health and accident insurance companies have their own peculiar designs as to the kind of coverage they will give, and the ultimate result is that for each and every insurance company in the United States, there are as many divergent forms.

However, it is not impossible for the busy doctor to comprehend and fill out obvious questions with pretty obvious answers; particularly when enough space is left in the forms to explain certain situations which cannot be answered with a "yes" or "no", but, this is not always, apparently, the intention of the insurance companies in the development of their forms. The doctor may not find himself in too much of a state of confusion in the metropolitan areas where he will probably deal with only one or two insurance companies. However, in the more or less rural areas where a doctor may be the medical examiner for twenty insurance companies, where he may have quite an industrial practice and deal not only with one compensation insurance company, but probably eight to twelve, he finds himself confronted with the fact that he must first be a student of composition in order to decipher just exactly what the insurance company means. It also sometimes seems that the medical director is intent on seeing whether the examining physician reads or not.

It would not at all be fitting in this article to ignore that some work has already been done in simplyfying these forms. A joint committee of the A.M.A. and the insurance companies have agreed in principle on the standard form for health and accident policies. However, the standardization has not been developed into practical operation to any great degree. We acknowledge, however, that a beginning has been made, and the old line companies, particularly, seem to be leading in this field.

It is very probable with a little bit of consideration and closer cooperation between the medical profession and the insurance industry all over the country, that we could develop a more or less standard form of medical examination and more or less standard form of industrial reports. It is our belief that when a doctor is dealing with a patient, his primary concern is the physical condition of that patient, the well being of that patient; and to decipher as easily as possible the insurability of the patient and the rehabilitation of the patient, which to us are much more important than being a student of grammer to decipher the language and the resultant answer.

It is not our intention, however, to take picks on the insurance companies; we are only bringing out some of the pitfalls that have arisen in the experience of the doctors in respect to the insurance forms, because there are getting to be more and more of them. Everybody has sick and health or accident policies, and it would seem that there are almost as many health and accident policies as there are patients. They come in with myriads of them. It seems as though the doctor's stenographer has to spend much time on getting out forms and forms, and the pile seems insurmountable at times. If more uniformity and simplicity of these forms could be manifested, it would be an immense service to the doctor, or at least to his secretary.

We wish to stress that though this is a problem which cannot be settled by the rank and file of the medical profession with individual insurance companies, and that this subject is of more or less limited value to the individual physician's effort in helping to promote the standardization of the insurance forms; but that it does enter into the medical economics field as far as the individual doctor's work is concerned. It must be revamped and further coordinated by the medical organizations on the state and on the national level, with the insurance industry and the American Medical Association taking the lead.

It is probable that every profession is just a little bit guilty in trying to impose their own technicalities, and technical phraseology upon the rest of the world, seeking to leave impressions of its own technical ability, at least with its language; and, in this respect we should probably get down to common ordinary wording when we are dealing with untrained personnel, especially when we are dealing with those individuals who want to be our friends.

KNOW YOUR SOCIETY

BACKGROUND and HISTORY

In the growth and development of personal interest in any organization each individual must come to the conclusion that the background and the history of that organization is important to him. To be a good citizen, an American must have a knowledge of the formative years, the fundamental rights established under our National Constitution in the early days of this democracy. The same is true of any physician desiring to be a good member of organized medicine.

The official proceedings of the governing body of any organization can be considered fundamentally, the history of the organization itself. Outstanding problems facing the medical profession in Illinois since the birth of "organized medicine", reflect the even or uneven tenure of its way through the years.

Printed transactions have come down to us since 29 forward-looking, progressive physicians gathered in Springfield on June 4, 1850 and concerned themselves seriously and thoughtfully with the reorganization problems they had to meet medically, economically and ethically.

These early meetings gave us many of our present forms and traditions, our committees on arrangements, practical medicine, surgery, obstetrics, drugs and medicines, and publications. One of the first actions taken by the group in Springfield in 1850 was to adopt a code of Medical Ethics based on that of the three year old American Medical Association. The second day of this meeting was given over to considering the ever present problem of recording births, deaths, marriages, and urging that the State of Illinois comply with the recommendations of the American Medical Association in these statistical problems. It was resolved that a special committee be appointed to "memoralize the Legislature at its next session, praying the enactment of a statute providing for the registration of births, deaths and marriages, and that the Committee cause a petition to that effect to be circulated as widely as possible through the State."

The first Constitution and By-Laws was little more than a skeleton to provide the frame under which the small group of physicians could work and meet for scientific and business purposes. The preamble of this Constitution contains the nucleus of Article II of our present Constitution and By-Laws. It might well appear today just as it was written then:

"Inasmuch as an institution so conducted as to give frequent, united and emphatic expression to the views and aims of the Medical Profession in this State, must at all times have a beneficial influence, and supply more efficient means than

have hitherto been available here, for cultivating and advancing medical knowledge, for elevating the standards of medical education, for promoting the usefulness, honor and interests of the Medical Profession; for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men, for exciting and encouraging emulation and concert of action in the profession and for facilitating and fostering friendly intercourse between those who are engaged in it: THEREFORE

BE IT RESOLVED, in behalf of the Medical profession Convention of the State of Illinois, that the members of the Medical Convention held in Springfield, June, 1950, and all other who, in pursuit of the objects above mentioned, are to unite with or succeed them, constitute a State Medical Society."

The Illinois State Medical Society, since its inception, has been a democratic body. The individual county society elects delegates to the House of Delegates which is the governing body. The House in turn elects the officers, and the members of the Council (Board of Trustees), who are responsible to the House, and whose duties are outlined in the Constitution.

Constitutional Committees are responsible to the House and the membership of these committees is selected by the House.

Council Committees, while appointed by the Chairman of the Council, report in detail to the House and work under directives from time to time.

The conduct of the individual physician is governed by his own confreres and members of his own county society.

For each individual member to "get the most out of" his Society, he should know how it operates, what his responsibilty is, what services it offers, what advantages he has as a member, what he can contribute, and what he can expect.

For these reasons, the first consideration should be "MEMBERSHIP".

MEMBERSHIP.

The Constitution and By-Laws (and if you don't have a copy, write and ask for one: Secretary's Office, 224 South Main Street, Monmouth) gives a complete outline of the qualifications for membership, the types of membership, etc.

MEMBERS: Article IV, Section 2. The members of this Society must hold the degree of Doctor of Medicine or its equivalent, be members in good standing of the component society, citizens of the United States, and be licensed to practice medicine in Illinois. Members of component societies shall be members of this organization and of the American Medical Association.

The following shall also be eligible for membership:

(a) every physician serving at headquarters as a full time employee of the American Medical Association;

(b) physicians, otherwise eligible for membership, and licensed in one of the States of the United States, but not licensed or registered in the State of Illinois, and who are not engaged in the active practice of medicine but are otherwise employed in an allied medical activity which does not require licensure, may on recommendation of a component society and upon approval of the Council become active members.

EMERITUS MEMBERS: Section 3. A member who has been in good standing for 25 years and who has reached the age of 70, may on application to and upon recommendation of his component society, be made an Emeritus Member and have all the rights and privileges of membership without the payment of dues to the component or state society.

The American Medical Association also exempts physicians 70 years of age or over from the payment of dues.

RESIDENCY MEMBERS: Section 4. After being licensed to practice medicine in the State of Illinois, a physician serving full time as a resident or fellow in an approved hospital in the State of Illinois, may enjoy all the privileges of full membership at a special rate *up to five years* after graduation in medicine, except that the time spent in military service may be excluded in calculating the five year limit. Thereafter the full rate shall apply. The special rate shall be $5.00 per capita per annum. A residency member must have a degree of Doctor of Medicine or its equivalent, must be a member in good standing of his component society and must be a citizen of the United States.

GOVERNMENT SERVICE MEMBERS: Section 5. Physicians serving as medical officers

of the United States Army, United States Navy, and the United States Public Health Service and those serving full time in the Veterans Administration, who are members of the component society, shall be eligible for membership in the Illinois State Medical Society so long as they are engaged actively in their respective service, and thereafter if they have been retired on account of age, or physical disability, or after long and honorable service under the provisions of an Act of Congress.

PAST SERVICE & RETIRED MEMBERS: Section 6. A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may on application to and upon recommendation of his component society be made a Past Service or Retired member, without the payment of dues to the component or state society.

(Special letters will be written by the State Society to the American Medical Association, asking for cancellation of dues for members in this category.)

HONORARY MEMBERS: Section 7. Honorary members shall be those physicians of Illinois or other states, territories, island possessions or foreign countries who have risen to prominence in the profession of medicine and who may be elected by a nine-tenths vote of the House of Delegates present at any annual meeting.

(At this time, there are no "Honorary Members" of the Illinois State Medical Society.)

To be a member in good standing:

(1) Your dues are paid to your county society secretary for your
County Society dues
State Society dues
American Medical Association dues.

As a member in good standing with dues paid for the current year, you

Receive your Illinois Medical Journal

Journal of the American Medical Association.

All Emeritus and Past Service members, Residency Members, etc., receive The Illinois Medical Journal.

Only those members who pay the $25.00 dues to the American Medical Association receive the Journal of the A.M.A. All members excused from the payment of A.M.A. dues must subscribe to the Journal if they wish to receive it, at the subscription rate of $15.00 per year.

PARTIAL PAYMENT OF DUES

This partial payment of dues has been established for those physicians upon whom the payment of full dues would work a financial hardship. Each case is considered individually. Each case must clear through the County Medical Society. This type of partial payment has been considered as a means of assisting the young physician just going into practice, the physician on a small teaching salary, etc.

The county and state society dues must be modified also if the A.M.A. dues are to be cut. This cut is developed on a percentage basis, for instance, the individual case under consideration might pay one-half his county dues, one-half his state dues and one-half his A.M.A. dues. Or the percentage might be determined as 2/3 of the totals.

Following action on the part of the county society, the secretary of that organization presents the case to the State Society for action on the part of the Council. Then the secretary of the State Society presents the case to the A.M.A. and asks that they, in turn, accept a percentage of the total dues.

Of course, the physician in question will not receive the Journal of the American Medical Association. He will have to subscribe at the rate of $15.00. He will, however, receive the Illinois Medical Journal.

As is always the case, the county society is the basis of this pyramid, and action in behalf of individuals deserving consideration must be instigated and developed at the county level.

No matter what type of membership the individual holds, his State Medical Society provides many services for him, protects his interest in many fields, gives him postgraduate education, develops and conducts his annual meeting each year. In order that each member of the Illinois State Medical Society may "know his Society" and what it does for him, a series of articles will appear in the Illinois Medical Journal outlining and developing the various phases of Society structure and activity.

CORRESPONDENCE



SILVER ANNIVERSARY BULLETIN FROM THE WOMAN'S AUXILIARY

Dear Doctor:

May we tell you of the delightful and interesting plans that are under way for our Twenty-Fifth Anniversary!

This year it will be the ladies' pleasure to meet with their husbands at the Sherman Hotel in Chicago on May 18, 19, and 20. In the event your wife is not a member of the Auxiliary, bring her along to be our guest while you attend your clinical conferences.

The wives attending the convention this year will be pleased to learn of the many departures from years gone by. Mrs. Harlan English, our beloved State President, has worked hard and long to attain what we feel will be an informative and interesting meeting. Good speakers will be presented and reports kept to a minimum. Let's make it the best attended convention in our history.

SPECIAL EVENTS

A magnificent formal Silver Ball under the direction of Mrs. John Orndorff and her committee, Tuesday, May 19.

Past Presidents' Luncheon with a 1928 Style Show which should prove to be one of the gayest highlights of the convention, planned by the luncheon committee — Mrs. Warren W. Young, Mrs. M. M. Hipskind, Mrs. William Somerville and their respective committees.

A Brunch at the famous Pump Room of the Ambassador Hotel.

There will be a series of important social functions planned for your wife's personal delight. Remember, *whether an Auxiliary member or not,* bring her along for the pleasant and memorable days planned in her behalf.

A detailed program will be published in the next issue of the Journal.

Mrs. Nicholas G Chester, Convention Chairman.

Mrs G. T. Buttice, Convention Press and Publicity Chairman.

SUMMER CAMP FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fifth season under the auspices of The Chicago Diabetes Association, Inc. from July 21, 1953 to August 10, 1953 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dieticians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $150.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary. Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.
Limited capacity requires prompt application.

NEW REVIEW OF LEUKEMIA RESEARCH

A new journal, aimed at furthering research on leukemia, is announced by Herman H. Henkle, Librarian of The John Crerar Library, 86 East Randolph Street, Chicago. It is published monthly under the sponsorship of the Lenore Schwartz Memorial Foundation through funds given by the parents and friends of Lenore Schwartz, a victim of leukemia. The publication consists of abstracts of the world's literature on the subject and is sent free to medical men working in the field of blood diseases, to research workers in this field and to medical libraries all over the world.

Dr. Raphael Isaacs, a specialist in blood diseases is Consulting Editor, assisted by a group of medical men widely known for their work in the field as an Advisory Committee. The Committee consists of Doctors Howard L. Alt, George J. Anday, Israel Davidsohn, Andrew C. Ivy, Leon O. Jacobson, Louis M. Limarzi and Karl Singer of Chicago; Dr. Charles A. Doan of Columbus, Ohio; Dr. John S. Lawrence of Los Angeles, California; Dr. Bernhard Steinberg of Toledo; and Dr. Maxwell M. Wintrobe of Salt Lake City, Utah. Don E. Nist, of the staff of Research Information Service of the Crerar Library, is Editor and responsible for the preparation of the periodical which is compiled, printed and distributed by the Library.

The advancement of medical science in the 20th century has made such rapid strides that we look on the conquering of disease as an accepted fact and fail to look behind the scenes at the research that makes this acceptance possible. In spite of this tremendous advancement there still are diseases which, when they confront us personally, leave us appalled and helpless — leukemia is one of these. The death of a brilliant young woman brought into being this new research tool, as a memorial to her and to the countless others who have perished from this dread disease, dedicated to progress of research toward preservation of these wasted lives.

The efforts of one investigator can stimulate the thought of another in increasing geometric proportions until success is achieved. That is the reasoning lying behind the decision of Lenore Schwartz' parents and friends to perpetuate her memory through this medium rather than through some other possible choice in the use of the funds donated to assist in eradicating a disease which leaves the medical world almost powerless. Lenore Schwartz was the twenty-three year old daughter of the Joseph A. Schwartzes, 1241 North Shore Avenue, Chicago and it was her intention to devote her life to scientific advancement. Leukemia cut short her life but the journal consecrated to her may be the means of giving life to future victims.

ADVANCE COURSE IN AUTO-RADIOGRAPHY

An advanced course in autoradiography and three basic courses in radioisotope techniques are course offerings of interest to medical and biological personnel planned this spring and summer by the Special Training Division of the Oak Ridge Institute of Nuclear Studies.

The autoradiography course will be held from June 15-25, and basic courses of four weeks duration will begin on June 8, July 6, and August 10.

The autoradiography course will be the second to be given at Oak Ridge, an earlier one having been given in the summer of 1951. It is intended for research level personnel using or planning to use this technique in their research.

Lectures, consultations, laboratory demonstrations and discussions will comprise the course. Leaders in the field will be on hand as lecturers and demonstration supervisors.

Subjects to be covered include both the application of the autoradiographic method and the theoretical bases of the method.

Application forms and additional information may be obtained from the Special Training Division, Oak Ridge Institute of Nuclear Studies, P.O. Box 117, Oak Ridge, Tenn.

REQUESTS REPRINTS ON STRESS, ADAPTIVE HORMONES

In perusing the current literature with which this journal is concerned, we note that an ever increasing number of its articles deals with problems pertaining to research on "stress" and the so-called "adaptive hormones" (ACTH, STH, corticoids, adrenergic substances, etc.,).

We are writing you because, in our opinion, the success of research in this complex and rapidly developing field largely depends upon the prompt availability and evaluation of relevant publications, a task for which we should like to solicit the assistance of your readers.

In 1950, our Institute has initiated the publication of a series of reference volumes entitled "Annual Reports on Stress" (Acta Medical Publishers, Montreal) in which the entire current world literature is surveyed every year (usually between 2000 and 4000 publications). Up to now, we had to compile the pertinent literature partly from medical periodicals, monographs, abstract journals and partly from reprints sent to us by the authors themselves. Of all these, reprints proved to be the best source of data which we felt deserved prompt attention in our annual reports. Hence, in the past, we have sent out several thousand individual reprint requests to authors of whom we knew that they are currently engaged in research on stress and allied topics. Even this procedure did not give us the wide coverage which would be desirable, because it is materially impossible to contact all these authors individually and it often takes too much time to get the requested reprints.

It is evident that in order to insure prompt inclusion of publications in the annual reports, these surveys must develop into a cooperative effort between the authors of original papers and the reviewers. This cooperation was greatly enhanced of late by the publication of announcements, in several medical journals, encouraging investigators interested in stress research to send us their reprints for this purpose as soon as they become available.

We should be grateful if by the publication of this note, you would also bring this problem to the attention of your readers. Hans Selye, M.D., Ph.D., D.Sc., F.R.S. (C), Professor and Director of the Institute of Experimental Medicine and Surgery. Alexander Horava, M.D., Co-author of the "Annual Reports on Stress". University of Montreal, Montreal. Canada.

AMERICAN GOITER ASSOCIATION MEETS IN MAY

We would appreciate it if you would announce in your Journal the time and place of the 1953 meeting of the American Goiter Association. This meeting will be held in the Drake Hotel, Chicago, Illinois, May 7, 8 and 9, 1953.

The program for the three day meeting will consist of papers and discussions dealing with goiter and other diseases of the thyroid gland.

George C. Shivers, M.D.,
Corresponding Secretary.

AMERICAN ASSOCIATION OF INDUSTRIAL NURSES

Members of the American Association of Industrial Nurses from all parts of the nation will meet in Los Angeles April 18 to 24 for their 11th annual conference and the first to be held west of the Mississippi.

Highlight of the conclave will be a daily series of "shop talk" sessions designed to help industrial nurses improve and better organize their health services. These sessions will be conducted under the supervision of Dr. Martin P. Anderson of the department of conferences and special activities at University of California at Los Angeles.

Mary Mulvahill of North American Aviation Corp. at Los Angeles will be conference chairman. Elsie Williams of Northrop Aircraft Corp. of Hawthorne and president of the Southern California Chapter of the Association will be co-chairman.

The organization will meet simultaneously with the Industrial Medical Association, American Conference of Government Industrial Hygienists, United States Navy Industrial Health Organization, American Association of Industrial Dentists, and American Industrial

Hygiene Association. The combined meeting of all groups will be known as the 1953 National Industrial Health Conference.

ARMY SURGEON GENERAL RETURNS FROM FAR EAST

Major General George E. Armstrong, The Army Surgeon General, returned to Washington on January 28 after a 25-day visit of Army medical installations in Korea, Japan, Okinawa and Hawaii. In Korea General Armstrong also visited battalion aid stations on the fighting front. The General reports high morale among Army medical personnel at all points visited. He was accompanied by Dr. Elmer Hess of Erie, Pa., consultant in Urology to the Army Surgeon General; Col. Floyd L. Wergeland, MC, Chief, Education and Training Division of his Office; and Lt. B. W. Wingo, MSC, his staff assistant.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR APRIL

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the April schedule of clinics for physically handicapped children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The April clinics are:

April 1 — Hinsdale, Hinsdale Sanitarium

April 2 — Cairo, Public Health Building

April 2 — Sterling, To be announced prior to clinic

April 7 — Flora, Clay County Memorial Hospital

April 8 — Elgin, Sherman Hospital

April 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

April 9 — Springfield, St. John's Hospital

April 10 — Chicago Heights (Rheumatic Fever)

April 14 — Danville, Lake View Hospital

April 14 — East St. Louis, Christian Welfare Hospital

April 14 — Peoria, St. Francis Hospital

April 14 — Quincy, Blessing Hospital

April 15 — Chicago Heights, St. James Hospital

April 15 — Alton, Alton Memorial Hospital

April 21 — Shelbyville, First Methodist Church

April 22 — Springfield (Cerebral Palsy), Memorial Hospital

April 23 — Mt. Vernon, Masonic Temple

April 23 — Rockford, St. Anthony's Hospital

April 23 — Watseka, American Legion Home

April 24 — Chicago Heights (Rheumatic Fever), St. James Hospital

April 28 — Effingham (Rheumatic Fever), Douglas Township Building

April 28 — East St. Louis, St. Mary's Hospital

April 28 — Peoria, St. Francis Hospital

April 30 — Bloomington, St. Joseph's Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

D. J. DAVIS LECTURE

The tenth D. J. Davis lecture on Medical History at the University of Illinois Collage of Medicine, Chicago, will be given on May 6th by Dr. Richard H. Shryock, Director, Institute of the History of Medicine, The Johns Hopkins

University. The title of his lecture is Changing Concepts in American Medicine Over Three Centuries. The lectureship was established in 1943 by the associates and friends of Dr. David J. Davis upon his retirement as Dean of the College of Medicine.

ARMED FORCES MEDICAL SYMPOSIUM TO BE HELD AT GREAT LAKES

Several internationally-known speakers will appear at a joint armed forces medico-military symposium to be held May 6-8 at the U. S. Naval Hospital, Great Lakes, Ill.

Among the subjects slated for discussion are atomic energy, disaster control in the event of an atomic war and reserve matters.

The symposium will be open to all officers of the medical, dental, nurse and medical service corps of the armed forces. It is sponsored by the Commandant, Ninth Naval District, Commanding General, Fifth Army and Commanding General, Tenth Air Force.

Retirement and promotion points will be given all reserve medical officers, not on the inactive status list, who attend this meeting.

GRANTS-IN-AID, CANCER RESEARCH

The American Cancer Society, Illinois Division, Inc., has been the beneficiary of several legacies and has, therefore, limited funds which it is desired to expend for the support of responsible cancer research projects. Accordingly, applications will be received for grants-in-aid for cancer research to be considered by a special committee.

Application forms may be obtained from John A. Rogers, M.D., Executive Director, American Cancer Society, Illinois Division, Inc., 139 North Clark Street, Chicago.

Applications should contain full details concerning the nature of the project and what is hoped in the way of accomplishment. Sufficient information should be supplied to assure the committee that personnel concerned in the research is qualified and that adequate facilities are available.

LOWER ABDOMINAL PAIN

Pain is a symptom which is common to all systems of the body. The genital tract is, of course, no exception in this respect. Pain is the most common complaint given to the gynecologist as a reason for an examination. Unfortunately, it is too often customary to regard all feminine pain located anatomically between the umbilicus and the perineum as originating in the generative apparatus, especially if it is associated with or exaggerated by menstruation. It matters little if the pelvic organs are found to be normal for the idea is firmly fixed that pelvic pain is genital, always. There is an unfortunate tendency at times to invent pelvic pathology such as cystic ovary or prolapsed ovary, or even a displaced uterus in order to fit the patient's symptoms. In a desire to relieve pelvic pain, many operations are done in the name of gynecology. W. F. Mengert stated in a report given in 1949 that 75 per cent of 1320 ovaries removed during a five year period in a local hospital were histologically normal or contained only follicular or corpus luteum cysts. Norman F. Miller, in a paper entitled "Hysterectomy, a Therapeutic Necessity of Surgical Racket", found that in 22 per cent of the cases, the main symptom and often the only one, was lower abdominal pain.—*C. Gordon Johnson, The Gynecologist Evaluates Lower Abdominal Pain. New Orleans M. & S. J., April 1952.*

ORIGINAL ARTICLES



Urological Problems in Infants and Children

Knowlton E. Barber, M.D.
Chicago

Urology in children is a specialty unto itself. Congenital anomalies comprise most of the pathological conditions found, but these anomalies must be diagnosed and corrected early in life before irreparable damage is done. Very few subjective findings are present early in life. The infant does not complain of pain, frequency, burning, etc., Regurgitation of feedings or crying on urination may be the only subjective finding. Young children usually complain of stomach ache or loss of appetite along with pain on urination. Diurinal enuresis may be the only finding.

Objective findings are far more important in these cases, such as red blood cells or white blood cells in the urine, palpable masses in the abdomen, urinary incontinence, fever of undeterminate origin or inability to gain weight.

The urologist was confronted with the problem of developing new methods of examining these cases. New instruments, such as small cystoscopes capable of examining the urethra and bladder of infants and children, as well as catheterizing the ureters and to make pyelographic studies, were necessary. These instruments had to be devised and perfected. These examinations and studies were to be performed without causing damage to the urinary tract or introduction of infection to the urinary tract as this also was a serious problem in those days.

The advent of I.V. or I.M. pyelograms have been of tremendous aid to us. More efficient x-ray machines have also been most helpful. These instruments and methods having been developed, new standards of selecting cases for complete urological studies had to be determined. New standards of selecting symptoms or physical findings, or both, were established for recommending complete urological work-up. Pus cells in the urine, especially in the male patient; recurring attacks of pyuria; recurring attacks of unexplainable abdominal pain, especially when

Presented before the Section on Pediatrics, 112th Annual Meeting, Illinois State Medical Society, May 13-15, 1952.

associated with vomiting or regurgitation of feedings but with no other symptoms or findings — in infants inability to gain weight and regurgitation — these symptoms may lead to the diagnosis of appendicitis — a normal appendix is removed and at this point the surgeon does not follow thru by exploring the abdomen, more especially the kidneys. Wilms tumors and hydronephrosis are the most common cases operated for acute appendicitis and the patient is not benefited by the appendectomy. Also more thorough urological studies should be made in hematuria, either gross or microscopic, and enuresis, especially diurinal as some unusual and correctable pathology has been found. All cases where a mass is palpated in the abdomen should have an intravenous or intra muscular pyelogram done to rule out urinary tract pathology.

During these urological studies some interesting abdominal pathological findings of the urinary tract have been demonstrated. Certain x-ray findings have been demonstrated that have formulated criteria for diagnosing intra and extra urinary tract pathology most helpful to both the urologist and the abdominal surgeon.

The urologist may be most helpful in diagnosing some abdominal condition — he at least can say whether the urinary tract is or is not involved — that the pathology is outside of the urinary tract but in the retro peritoneal space, or that the pathology is not in the retro peritoneal space but must be located in the peritoneal cavity — thus aiding the surgeon to determine the method of approach to use.

The abdomen of infants and children is not unlike that of the adults in many respects. The gall bladder, pancreas and gastro-intestinal tract are free of some diseases more common to adults, such as cancer, ulcers, gall stones, etc. to name a few of them. But the genito-urinary tract is not so fortunate in being free of the same diseases as found in adults. The most common causes of pathology in the urinary tract are due to congenital anomalies such as anomalous blood vessels causing obstruction of the upper, middle or lower end of the ureters, lack of normal canulization of the ureters or urethra; reduplication of the kidneys and ureters, maldevelopment of the bladder and urethra, or both, such as hypospadias, extrophy of the bladder, epispadias, etc.

Some pathological condtions are similar to adult pathology such as tumors of the kidney, hydronephrosis, ureteral strictures, aberrant blood vessels causing hydronephrosis, bladder neck obstructions, and diverticula, both congenital and acquired, to name a few common to both.

Hydronephrosis: Wether it be due to intrinsic obstruction such as strictures of the ureter or ureteral mucosal folds; extrinsic obstruction due to aberrant blood vessels, adhesive bands or peritoneal tumors, to name a few of them, hydronephrosis may be easily overlooked. The symptoms may be abdominal pain with, or perhaps without, vomiting or fever. Urinalysis is usually negative unless infection is present. Leukocytosis may be present even in the absence of infection. When the urine is negative urinary tract pathology is usually discounted by the physician. Intravenous or intramuscular pyelograms should be done to determine the presence or absence of urinary tract pathology. It is important to determine where the obstruction is located in order to institute proper therapy. Dilatation starts behind the point of obstruction.

Reduplication of the kidneys and ureters or so-called double kidneys and ureters may be unilateral or bilateral. Due to the anatomical relation of the two ureters the ureter to the upper half of the kidney crosses the second ureter someplace along their course to the bladder. This may cause intermittent obstruction with attacks of abdominal pain — later hydronephrosis, then infection with pyelitis of the recurring type. If it is on the right side, appendicitis may be suspected when infection with pyuria is absent.

Intravenous or retrograde pyelograms will demonstrate this anomaly. The pyelogram is characteristic, showing a double kidney and ureter. When the upper half is not demonstrated the lower half shows a middle and inferior calyces only — the superior calyx being absent.

Mesenteric Cysts whether single or multiple may simulate the cystic kidney. Mesenteric cysts are usually more mobile, transmit light and have a smooth surface; whereas the congenital multilocular kidneys are not mobile, may have an irregular surface and they may or may not transmit light. Congenital polycystic kidneys do not. The congenital multilocular cystic kidney is unilateral, may transmit light — is usually present at birth and diagnosis can be made by intravenous or retrograde pyelograms.

In the case of Mesenteric cysts, the pyelograms

will be normal — displacement of the cyst medially or laterally will not displace kidney. Congenital polycystic kidneys show elongation of the calyces with wide separation of the calyces and the ureter may be displaced medially. In congenital multilocular cystic kidney the ureter is not canulized or is impervious so the ureteral catheter will not enter the kidney pelvis. A retrograde pyelogram will show a portion of the ureter but no pelvis or calyces.

The two most common tumors of the abdomen in children are tumors of the kidney and tumors of the sympathetic nervous system, the neuroblastoma sympatheticum.

Tumors of the Kidney: Unfortunately, tumors of the kidney are silent. In our series one of the kidney are silent. In our series one out of ten prevented hematuria. The primary complaint is related to an enlargement of the abdomen or a firm swelling in the abdomen usually discovered by the mother while bathing or dressing the child. One mother noticed that the diaper was more difficult to put on the baby because of an enlargement of the abdomen. Or they may produce pain in the abdomen quite often diagnosed as appendicitis. If the appendix is removed and found to be normal, the abdomen should be explored for a tumor of the kidney or a hydronephrosis, or some pathology of the urinary tract.

These kidney tumors usually occur in the first or second year of life. Neuroblastomas later. Hematuria is rarely a symptom, either grossly or microscopically, in either condition. In our series of cases, pyelitis with fever has been more frequent in neuroblastomas than in kidney tumors; the pressure of the tumor on the kidney pelvis or ureter in neuroblastoma sympatheticum is the cause of obstruction. Wilms tumors, embryomas of the kidney, renal carcinoma or sarcoma, embryomal adenomyosarcoma, are some of the diagnoses given to this kidney tumor, depending upon the predominating type of tissue present.

The Limitations of Hormonal Therapy in Gynecology

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At the outset I would like to state that this talk concerns therapy with gonadotrophins and sex steroids, and is in no way involved with other pituitary, adrenal, pancreatic, or thyroid hormones. My remarks will therefore be confined to the treatment of gynecological diseases with male and female sex steroids and with the various different gonadotrophins. The gynecological diseases are considered to be abnormalities at the time of the menopause and sterility problems, in addition to various menstrual abnormalities such as amenorrhea, menometrorrhagia, dysmenorrhea, pre-menstrual tension, etc.

Within the past few years there have been several interesting papers published either in the Journal of the American Medical Association or the American Journal of Obstetrics and Gynecology which take surgeons in general, and gynecologists in particular, to task for carrying out many possibly unnecessary operative procedures for the treatment of gynecological abnormalities including sterility[1,2,3,4,5]. That these papers point out a serious failure in our therapeutic activities, there is no doubt; and these very criticisms represent the most healthy of all possible attitudes which doctors can assume towards each other, for it is only by constant self and mutual criticism that we can maintain the high standards of medical care which we of the medical

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profession owe to everybody in this country.

I am sure that we all agree that the basic motivation of the vast majority of these "unnecessary" operations (if they were unnecessary) was one of good will and a desire to cure the patient of a complaint from which she was suffering. The fact that the therapy was ill-advised or missed its mark is one which is not only easy to identify by hindsight but also one which can be eliminated by continued diffusion of knowledge concerning the various diseases and their treatments through the medium of the medical press and medical meetings of the type which we are attending at the present moment.

It is therefore, not in the spirit of criticism, but with ideas of mutual assistance that I wish to take this opportunity to point out the failures of another type of therapy on which there has been great concentration in the past few years, and this is hormonal therapy of gynecological disorders. Certainly, it is a lot easier to make destructive than constructive criticisms; on the other hand it does seem to me that hormonal therapy of the type which I am about to describe is so extensively over-used that some of its failures should be pointed out and emphasized. It is a great temptation to try to treat menstrual abnormalities with hormonal products before making an adequate diagnosis; in fact it is as much of a temptation to do this as it is to treat infection with antibiotics before attempting to locate the etiology and area of the infection. It is unfair to view with censure the attempts of the busy practitioner or specialist to make short cuts of this type especially since these short cuts are very often therapeutically successful, and because the physician is motivated by the desire not only to effect a cure as rapidly as possible, but also to save the patient the rapidly mounting expense of a diagnostic investigation. The only trouble with this type of what may be called emperical or shotgun therapy is that it not only frequently misses its mark but it also fails to disclose an underlying pathological condition, which, if not properly identified and treated, may result in disaster for the patient. As an example, it may be briefly mentioned that the hormonal treatment of undiagnosed menorrhagia, for instance, may be actually concealing a very crucial etiological factor such as carcinoma of the cervix or corpus uteri. Admittedly a thorough curettage of the cervix and endometrial cavity is an expensive and inconvenient bother which both the physician and patient wish to avoid, but the implication or failure to make a diagnosis in this situation is so obvious that it hardly seems necessary to emphasize it.

It is actually surprising how few are the menstrual disorders which have abnormal hormonal function as their main etiological factor, and I would go so far as to state that the most valuable therapeutic contribution an endocrine clinic can make in connection with gynecological disease is the *accurate identification* of the etiological factor involved. This may also sound like a surprising statement by someone who has been intimately associated with a gynecological endocrine clinic for over ten years and who, believe it or not, has high hopes for the usefulness of endocrine therapy. To say that possibly "familiarity breeds contempt" might be putting the idea too strongly, but observation of the many failures of hormonal therapy, in our clinic and elsewhere, emphasizes the necessity for being realistic, detached, and objective concerning our enthusiasms.

There is, obviously, not time to discuss the many etiological factors involved in the production of amenorrhea or menometrorrhagia, for instance; suffice it to say that we who are investigating these complaints must first eliminate all kinds of other factors before we accuse the glandular system or the so-called "thyroid-pituitary-ovarian-endometrial axis" as the cause of the abnormality of which the patient is complaining. Amenorrhea, for instance, may well be caused by local congenital or pathological abnormalities as well as systemic disease. Psychological factors undoubtedly have a pronounced effect in producing amenorrhea, and let us not forget that unsuspected pregnancy may be a cause of this menstrual abnormality. In a like fashion, abnormal uterine bleeding may also be caused by any of these local systemic or psychiatric factors and, therefore, it is incumbent upon us to thoroughly eliminate these possibilities by history, physical examination and laboratory investigation before we expose the patient to extensive therapy with estrogens, progesterone, male sex hormone or different types of gonadotrophin, which may all be ineffectual anyway. This also is frequently true in the investigation of the problem of sterility. All too frequently the case is seen in the sterility clinic of patients

who have had prolonged and extensive courses of hormone therapy before any tests have been done to determine tubal patency or even to determine whether or not their husbands are potentially fertile!

Let us consider some of the various steroids and gonadotrophins in more detail and determine what their physiological usefulness is; for by this means only can we determine whether or not they might be of any value in the treatment of these various gynecological abnormalities.

Estrogens. What do we use estrogens for and what is their specific action in the body? Obviously their greatest importance is in the production of secondary sex characteristics, and if the ovary has failed to elaborate this hormone for some reason or other it would seem almost specific therapy to use exogenous estrogen for replacement. This is certainly true up to the time of the physiological menopause. I would like at this point, however, to take the opportunity to condemn the fairly common practice of the prolonged and uncontrolled use of either natural or synthetic estrogens for long periods of time, occasionally extending into years, at this time of life. Nature has apparently so arranged the physiological process of aging in the female that her ovaries become non-functional, senile, and physiologically useless somewhere around the ages of 45 to 50. This physiological process of aging is a natural one just the way any other physiological process of aging is, and to try to postpone its inevitable course by prolonged administration of exogenous estrogen is as unphysiologic and psychologically unsound as trying to find the illusive fountain of youth by the many other processes to which Americans seem so prone, such as hair dyeing, face lifting, etc. One may very reasonably ask why a woman should not be given estrogens to the point of maintaining her menstrual life into advanced old age if she so desires. To this I believe there are two answers. The first and most sensible one is that there is no necessity for it, that nature has so arranged matters that a normal psychologically stabilized female should be as healthy, as happy, and as sexually capable and sexually satisfied following the menopause as before it. The second reason, which is possibly questionable, but certainly extremely important, is that estrogens may possibly be carcinogenic to the uterus or breast if they are given over long periods of time in large amounts. Let me be the first to say that there is no definite proof of this statement. There is, however, suggestive evidence that endometrial adenomatous hyperplasia, for instance, chronically induced by either endogenous or exogenous estrogen, may some day result in corpus carcinoma[6] and there are all too frequent allusions in our medical literature[7] to the association between prolonged estrogen therapy and breast cancer to allow us to treat the matter as a mere ephermal idea.

We are all, however, faced with the problem of treating patients at the time of the menopause who have multitudinous and various complaints which have frequently been attributed to their decrease in estrogenic activity. So far as is known at present hot flushes and vasomotor instability are the only actual menopausal symptoms which have in any way been proved to be due to the hormonal changes of estrogen deficiency and increased gonadotrophic output which occur at the time of the menopause. The multitudinous other subjective symptoms which do occur at this time must have a different etiology. Extensive studies of menopausal cases[8,9,10] have indicated that these subjective symptoms arise from various sources: medical, surgical, psychological. Hours could be spent on discussion of the treatment of the menopause — suffice it to say, however, that this condition, too, is sometimes elusive in its etiology. Frequently symptoms attributed to the menopause are actually being caused by medical or even surgical conditions the accurate treatment of which will result in much greater benefit to the patient than the casual use of estrogens given just because the patient happens to have reached this episode in her life.

Let us discuss the use of estrogens in the treatment of other menstrual abnormalities which may be considered pathological rather than physiologic.

It has been suggested that estrogens be used in the treatment of dysmenorrhea. Certainly the administration of sufficient amounts of estrogen so as to prevent ovulation and thus cause cyclic bleeding from proliferative endometrium prevents the cramps of idiopathic dysmenorrhea during the time in which it is administered. But the administration of large amounts of estrogen in this fashion for prolonged periods of time is inadvisable for reasons above men-

tioned and the use of small amounts of estrogen in the treatment of dysmenorrhea is not particularly effective. Sixty to 75 per cent of patients suffering from dysmenorrhea, interestingly enough, are cured by practically any kind of therapy anyway; therefore it seems reasonable to conclude that 60 to 75 per cent of these patients have a psychological etiology for their problem and that their cramps are not due to physiological estrogen deficiency.

In problems of primary amenorrhea, especially in girls between 15 and 20, suffering from what might be considered a late menarche, the production of artificial bleeding by the use of exogenous estrogen may well retard what would otherwise be a gradual, normal, but late sexual development. Large amounts of estrogen depress pituitary function and therefore prevent an individual's pituitary from secreting sufficiently adequate amounts of gonadotrophins to stimulate their own ovaries to produce endogenous estrogen. Therefore this type of therapy may defeat the very purpose for which the exogenous estrogen is given.

The use of estrogens in inunctions in attempts to produce greater breast development or for other cosmetic purposes is probably not efficacious; or, if it is, may produce undesirable menstrual abnormalities. This also applies to the treatment of acne with estrogens. There are various and sundry other uses for estrogens described in the medical literature, some of which may possibly be useful, but let us always try to remember the basic physiological purpose of estrogen production by the ovary, and with this in mind, judiciously use exogenous estrogen therapy as a replacement for possible ovarian failure which is pathological rather than physiological.

Progesterone. In many ways progesterone is a sort of super-estrogen. It takes over where estrogen leaves off in the physiological process of the latter half of the menstrual cycle and of course during pregnancy. Progesterone, as the name implies, is a hormone necessary for the maintenance of gestation. It is, however, extremely questionable whether it is possible to administer enough of this substance exogenously to substitute for a basic endogenous lack of progesterone resulting from chorionic or ovarian tissue failure. In the treatment of threatened abortion, for instance, tremendous amounts of this substance would be needed to substitute for a possible failure of these structures to produce this hormone *if* this failure were thought to be a cause of the threatened abortion. It has been variously estimated[11,12,13] that 60 to 90 per cent of early abortions are due to faulty ova anyway and therefore therapy with any product in these cases is inadvisable and useless. The problem of *habitual* abortion will not be discussed here except to say that synthetic estrogen therapy in the treatment of this disease has been considered more efficacious than the use of progesterone, because stilbestrol may possibly stimulate the ovary to increase its own progestational activity. On the other hand, Eastman[14] has made a recent statement as follows: "As far as I am aware, not a shred of valid evidence has been advanced that stilbesterol has the slightest value in habitual abortion."

Progesterone has been advised in the treatment of pre-menstrual tension, for instance, a syndrome thought to be due to sodium and water retention as a result of increased steroid metabolism during the latter part of the menstrual cycle. If this hypothesis is correct, then any further steroid therapy, either ovarian or androgenic would certainly be contraindicated. Except for rare instances of usefulness in the therapy of certain types of menometrorrhagia, progesterone could well be discarded, and none of us or our patients be the worse off. Dr. George Corner, who with Dr. Willard Allen, discovered progesterone, isolated it and synthesized it, has been quoted as saying, (I don't know whether this quotation is accurate or not) that if he synthesized a barrelful of crystallized progesterone he then would not know quite what to do with it.

Gonadotrophins. Of these there are several kinds, the longest one in use therapeutically being the chorionic type. This is sold commercially under many trade names such as Antuitrin S, Follutein, APL, Pranturon, etc.

This product has been extensively used in problems of sterility, late menarche, menstrual abnormalities of all sorts and a dozen other conditions. So far as is known at present, chorionic gonadotrophin has no pronounced physiological effect in the female except to support and increase the activity of the corpus luteum; therefore, unless this therapeutic effect is desired it is doubtful if the drug is of much value. An-

other gonadoptrophin is that which is derived from pregnant mare's serum. This also is sold under a number of trade names such as Gonadin, Gonadogen, Equinex, Anteron, etc.

Pregnant mare's serum extract is supposed to contain a concentration of follicular stimulating hormone and it certainly does stimulate follicular growth — sometimes to the extent of cyst formation. I doubt if anyone now claims that it produces ovulation except in very rare instances. Various combinations of these and other gonadotrophins have been tried both in technic of administration and in the production of pituitary synergists. While occasional favorable reports have been received concerning these technics of therapy, the overall impression concerning their use by individuals who have subjected them to critical analysis is very disappointing. The same may be said of whole pituitary extracts from either horse or sheep. These substances have the additional danger of anaphylactic phenomena because of high content of foreign protein. Therefore if we discarded from our therapeutic armamentarium all gonadotrophic products the loss would not be very significant.

Testosterone. Testosterone is used in the female for the treatment of certain types of memstrual disturbances and in the treatment of endometriosis. As is the case with ovarian sex steroids enthusiastic reports have been published concerning the use of this substance but it is certainly a type of substitution therapy which can be used only sparingly and temporarily because of its masculizing effects. Without taking time to go into detail, the author knows of only one type of menorrhagia where the use of testosterone may be helpful. Furthermore its efficacy in the treatment of endometriosis has been questioned. Testosterone has often been spoken of as an "antagonist" to estrogen or as though the action of one neutralizes the action of the other. I wonder if this is actually true. They are both steroids which under certain circumstances might even be synergistic. Need we carry the "battle of the sexes" all the way down to the elemental chemical substances which are supposed to be responsible!

Because of my desire to concentrate on the limitations of hormonal therapy I have naturally not discussed the various situations where the administration of sex steroids and gonadotrophics may be of some use. That these situations occur there is, of course, no doubt, but I submit that they are much less frequent than we all of us have hoped and the efficacy of therapy with these hormones is much less satisfactory than we have all desired. Like other investigators in this field, we are always hopeful that we may find new and satisfactory uses for the hormones we have available, and we have great hopes that the physiologists and chemists will provide us with new material which will be more efficacious than what we have at present. It might be appropriate at this point to mention a few general principles of hormonal therapy which may apply to the treatment of any of the gynecological abnormalities which are thought to have any endocrine etiology.

1) Is the symptom from which the patient is suffering actually due to a hormonal or endocrine abnormality.
2) Is it necessary to treat the symptom.
3) Do we have any available hormone which when administered to a patient will cure her or alleviate her symptoms.
4) Will the adminstration of such a substance do any immediate or remote harm.

I think if we consider these aphorisms or respond to some other such plea for caution in the indiscriminate use of sex steroids and gonadotrophins we will ultimately obtain a much more satisfactory result with our patients and thus fulfil our responsibilities more efficiently and accurately.

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Allergy in Relation to Deafness

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The tissues most susceptible to allergic disease are three: the *skin,* the *gastrointestinal mucosa* and the *respiratory mucosa.* These are the tissues through which pathogenic microorganisms must pass to invade the body. Accordingly these tissues possess to the highest degree the ability to elaborate specific antibodies against foreign invaders. In certain persons with an inherited predisposition these tissues also elaborate antibodies against ordinarily harmless foods or inhalants. When such a person inhales or eats the substance to which antibodies have been produced a reaction occurs in his tissues due to union of antigen and antibody, with tissue damage, liberation of histamine, edema, eosinophilia, smooth muscle spasm and increased flow of mucous from mucous glands. This is known as the allergic reaction, and hay fever is the classical example in the respiratory mucosa.

In recent years we have learned that the majority of chronic nasal and sinus disease is not primarily an infection, but is basically allergic, with superimposed secondary infection in the more severe cases due to the chronic edema and stasis. It is not so well known that chronic allergy of the middle and inner ear causes a considerable number of cases of deafness.

Allergy of the middle ear should not be surprising, for the eustachian tube and middle ear are lined by the same respiratory mucosa that readily elaborates antibodies against foreign proteins and so often develops clinical allergies. Allergy of the labyrinth seems less easy to explain until we reflect that the endolymphatic labyrinth is a derivative of skin, coming from the ectodermal otocyst, and skin is another of the tissues that easily becomes sensitized to foreign proteins.

In recent years the condition of endolymphatic hydrops has been recognized and diagnosed with increasing frequency as a cause for nerve deafness. The majority of cases of endolymphatic hydrops are of unknown origin: the patient shows the characteristic syndrome of a low tone perceptive deafness that usually fluctuates widely at least in the early stages: the symptom of diplacusis can be demonstrated in many cases; the patient complains of a sense of pressure or fullness in the ear, a roaring type of tinnitus and attacks of vertigo. Not all of these symptoms need be present in any one case to justify the diagnosis of labyrinthine hydrops.

While the majority of cases are of unknown etiology, a very definite minority are the result of a specific allergy of the endolymphatic labyrinth to a food or an inhalant. *In every case of labyrinthine hydrops the possibility of an underlying specific allergy should be thought of.* If the patient also has other allergic symptoms such as asthma, an allergic rhinitis, dermatitis or gastrointestinal symptoms from certain foods, an allergic etiology for the inner ear symptoms should be strongly suspected.

The diagnosis of the specific allergen in allergic labyrinthine hydrops presents considerable difficulties due to the marked spontaneous fluctuations in symptoms. Thus the patient who improves on elimination of a food might have improved if nothing had been done. When the patient has other allergic symptoms such as a chronic rhinitis the discovery of specific allergens to which he is allergic is greatly facilitated. As in chronic nasal allergy, the skin tests are of limited value in making a diagnosis. Of greater value is the history, while the final proof of an allergen lies in the therapeutic test: the relief from symptoms when the substance is removed (or treated for), and the recurrence of symptoms when the patient is reexposed to the allergen.

Case 1. Mr. H.S., aged 34, complained of an attack of rotary vertigo, tinnitus and fullness in the right ear with a unilateral hearing loss, of 3½ weeks duration, not improved by repeated inflations and other

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local treatment by an otologist. There was a definite history of hay fever of many years duration and daily headaches for several years. On the basis of the hearing tests showing a low tone perceptive loss with diplacusis, a diagnosis was made of labyrinthine hydrops, possibly allergic.

Skin tests with a few common foods and inhalants revealed strongly positive reactions to cigarette smoke, housedust and ragweed. Since he was a heavy smoker, consuming 2 packages of cigarettes daily, allergy to cigarette smoke was suspected as a major factor. Complete cessation of smoking was followed by a very prompt and complete clearing of the persistent dizziness, roaring, fullness and hearing impairment, and a disappearance of the daily headaches of several years duration, and he has remained free from trouble for more than a year.

Case 2. Mr. W. G., aged 42. complained of an attack of vertigo, with tinnitus and loss of hearing in the left ear for one year. A diagnosis of labyrinthine hydrops was made on the basis of a low tone perceptive hearing loss of the left ear. A search for a possible allergic factor revealed that he had been a frequent and large consumer of garlic for many years and was a heavy smoker. Remembering that the elaboration of antibodies is greatest against substances frequently inhaled or ingested, garlic was suspected despite a negative skin test. Omission of garlic and tobacco resulted in a prompt and complete clearing of the ear symptoms of one year's duration.

Deafness due to allergy of the middle ear is encountered more frequently than allergic inner ear deafness. Three main forms are seen: allergy of the eustachian tube mucosa with tubal occlusion and a secretory otitis media, allergy of the middle ear and tubal mucosa with a chronic suppurative otitis media and allergy of the middle ear and tubal mucosa with repeated attacks of acute otitis media.

In any case of secretory otitis that is not due to an obvious obstruction of the tube by tumor or adenoid, and that resists the usual treatment of inflations and paracentesis, an underlying allergy should be looked for. If there is also a chronic nasal allergy an allergic etiology for the secretory otitis is probable.

Case 1. Mr. M.V.M., aged 50, complained of deafness in the right ear of 3 months duration. Repeated paracenteses and inflations had failed to clear up the secretory otitis with a high tone conductive loss. Chronic nasal stuffiness and post nasal discharge in the winter suggested a nasal allergy to housedust. Despite a negative skin test, injections of dust extract 0.05cc 1-10,000,000 dilution resulted in a prompt and lasting clearing of this secretory otitis, which had resisted the usual therapy.

Case 2. Mr. V.P., aged 34, complained of chronic draining ears continuing since the age of 16. Smears of mucoid aural discharge revealed eosinophiles on each of several examinations. Chronic nasal blocking and post nasal discharge suggested a nasal allergy, possibly to dust. Despite a negative skin test to dust, injections of dust extract 0.2cc of 1-1,000,000, dilution resulted in immediate drying of the ears and clearing of the nasal symptoms. Closure of the perforation in the right ear was then carried out with restoration of hearing to the practical level.

Case 3. Mr. R.V.W., aged 8½, complained of impaired hearing and repeated attacks of otitis media since early childhood. A chronic nasal blocking with thick mucoid discharge suggested a nasal allergy. This was confirmed by finding eosinophiles in the nasal smear. Despite negative skin tests, allergy to egg and housedust was demonstrated, with a complete clearing of the nasal symptoms and marked improvement in the hearing for the first time in many years, and with a marked reduction in the frequency and severity of the attacks of acute otitis media.

Conclusions: Many cases of middle ear deafness are the result of an allergy of the tube with a secretory otitis, or an allergy of the tubal and middle ear mucosa with a chronic suppurative otitis or recurring acute otitis. Until the allergic factor is recognized and dealt with the condition tends to persist and to resist all other therapy.

Some cases of nerve deafness are the result of allergic labyrinthine hydrops and clear up only when the allergic factor is recognized and adequately controlled.

As in chronic nasal allergy, allergy of the middle or inner ear is suspected when there are other allergic symptoms, when the aural discharge is very mucoid and resists the usual therapy, and when eosinophiles are found in the secretions. As in chronic nasal allergy, the skin tests are only of limited aid in diagnosing the specific allergen, and must not be depended upon to make the diagnosis. The history is more helpful than the skin tests. The final proof of the allergen is the therapeutic test. As in the treatment of chronic nasal allergy, the best results in allergic deafness will occur only when the otolaryngologist learns to make his own allergic diagnostic studies and carries out his own allergic management of these cases.

DISCUSSION

Question: I should like to ask whether Dr. Shambaugh increases the strength of the dose or maintains it at the same level. Also, does he use x-ray treatment, and is there hypertrophy of the tissues when there is not spontaneous resorption?

Dr. George F. Shambaugh, Chicago: We follow the Hansel method of dilute dosage therapy, which consists in finding the optimum dose and in not increasing the strength beyond this optimum dose. The

optimum dose will vary from between the extremes of 1 to 1 quadrillion to 1-100,000 dilution. Most cases range between 1 to 100 billion and 1 to 10 million. The optimum dose in a particular case is found by trial and error. As soon as the dosage that gives clinical relief is found, the patient is maintained on that dosage without any build-up.

With regard to x-ray treatment, a few years ago there was a vogue for irradiating the nasopharynx for hearing impairments in children. The rationale is to shrink lymphoid tissue in or around the orifice of the Eustachian tube for those cases of hearing impairment due to tubal occlusion, i. e., secretory otitis media. In our experience the majority of these cases are allergic and respond better to allergic management than to other forms of therapy, including radiation. The possibility of permanent tissue damage must always be kept in mind with radiation therapy, and for this reason allergic control when indicated is preferable.

Present Day Management of Diseases of the Thyroid

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Chicago

The thyroid picture has changed dramatically within the space of a few years. Largely as a result of the widespread use of iodine prophylaxis, there has not only been a striking reduction in the incidence of simple goiter, but unexpectedly, the frequency and character of thyrotoxicosis has also undergone remarkable alteration in the past two decades. In addition, the introduction of new therapeutic methods has profoundly affected the management of thyroid diseases. Indications for surgery have become modified in response to changing concepts as to the relation of goiter to carcinoma of the thyroid gland. The therapeutic picture is still in a state of flux, and its further evolution can only be tentatively predicted on the basis of current trends. I shall present the management of thyroid disease as of today, with the anticipation that further modifications will have to be made to keep pace with the continuing progress.

Simple Goiter. Many non-toxic nodular goiters are being removed today that would not have been considered proper indication for surgery a few years ago. This stems from the reports which show a surprisingly high incidence of cancer in the surgically excised non-toxic nodular goiters. While the figure varies from clinic to clinic, the pattern is fairly consistent. The highest frequency has been reported by Cole and his group. In two successive series of cases, they have found that one out of every six non-toxic nodular goiters removed in their clinic has been malignant, and of the solitary nodules, *one* in *four* has been carcinoma. With this appallingly high incidence, it is no wonder that the routine removal of all nodular goiters and particularly, of all solitary nodules, has been advocated.

There is, happily, another side of the picture. Time does not permit me to present the considerable body of evidence which we have accumulated, which proves that the hazard of carcinoma in nodular goiter has been vastly exaggerated, and that the current hysteria for the removal of every lump discovered in the thyroid gland is unwarranted. Nevertheless, in all groups, including our own, many more simple nodular goiters are being removed than was the case a short time ago. I consider the indications for operation in non-toxic nodular goiter to be as follows:

1. *Pressure symptoms.* Compression, deviation or angulation of the trachea or venous congestion call for operative relief. One should be

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careful, however, to find objective signs of compression, chiefly by A-P and Lateral x-ray visualization of the trachea. Subjective symptoms of irritation, cough or difficulty in breathing are often results of suggestion, when a patient has been told she has a goiter.

2. *Substernal goiter.* Once a goiter has descended into the thoracic introitus, it should be removed. Procrastination will only permit enlargement, further descent, adherence to the pleura and eventual operative difficulty when surgery can no longer be postponed.

3. *Cosmetic impairment.* In view of the small operative risk involved, I would not hesitate to remove an unsightly lump in the neck as readily as I would a disfiguring scar or mole.

4. *Atypical toxic symptoms.* We are occasionally asked to remove a goiter because of bizarre and otherwise unexplained findings which are not those of typical hyperthyroidism. If the relationship seems reasonable, we accept this indication.

5. *Suspicion of carcinoma.* Thyroid masses of recent appearance; rapidly growing nodules; fixed, firm or irregular masses; adherence to or infiltration of surrounding structures; in short, any local finding that suggests that the mass in question may be more than a simple nodular goiter, of course, calls for its removal.

Toxic Goiter (Hyperthyroidism, Thyrotoxicosis). The indications for therapy in hyperthyroidism are definite. When the diagnosis of toxic goiter is made, treatment must follow. The choice of treatment, however, is another matter. Until the recent war, the management of toxic goiter had been generally standardized. Preoperative preparation with Lugol's solution followed by subtotal thyroidectomy had been accepted as the best form of treatment. The mortality was low, complications were infrequent, and the results were excellent. Since the war however, two additional measures have been introduced which must be weighed against the former methods in the management of thyrotoxicosis.

The first of these measures was the use of the *antithyroid drugs.* It was found that a group of drugs, chiefly compounds of thiourea possessed the capacity of blocking the synthesis of thyroxin within the thyroid gland. Administration of these preparations, of which propylthiouracil was the most widely used, brought about a more-or-less prolonged remission of the manifestations of hyperthyroidism. It naturally followed that attempts were made to cure the disease definitively by medical means alone. The original reports were encouraging. The results appeared to be as favorable as those with surgery. However, as time has gone on, successive reports have shown increasing numbers of patients who were either unable to continue taking the drugs, or who showed evidences of recurrences despite its use, and had to be operated upon. One can now state that for routine use, medical treatment with antithyroid drugs is not comparable to surgery. These medical agents have been relegated very largely to an important role in the preparation of patients for thyroidectomy.

The second of the newer measures was the use of *radio-active iodine,* and here the picture is entirely different. All reports on the use of this agent have been favorable, and there is general agreement that the results are equally as good as those obtained by surgery. From the standpoint of the patient, there can be no question as to the preferability of the "atomic cocktail" to operation. A swallow of odorless, colorless and tasteless water comprises the treatment, without the weeks of preoperative preparation, the hospitalization, the anesthetic, operation, postoperative discomfort, permanent scar, and all else that is implied in thyroid surgery.

Despite these obvious advantages, it is generally believed that the radioiodine treatment is not ready to be recommended for the routine management of hyperthyroidism. As of today, the treatment of choice remains preoperative preparation and subtotal thyroidectomy. This opinion is based upon the fact that the period of observation of patients is still too short to permit its final evaluation; that the hazard of remote carcinogenesis has as yet, not been entirely disproved, and that optimal dosage and possible side-effects are not yet entirely known. In support of this position is the appearance in recent months of reports of the first cases refractory to radioiodine, and of severe thyroid crises following the use of larger doses of the drug. The first recorded fatality from thyroid storm following radioiodine will appear shortly in the Illinois Medical Journal.

Despite these reservations, I believe that radioactive iodine has proved itself to be an excellent

means of treatment for primary hyperthyroidism, and that it will probably largely displace surgery for this disease. In the nodular goiter with hyperthyroidism, however, surgery will continue to be the preferred treatment. While the symptoms of thyrotoxicosis can be controlled by the radioiodine, the nodular goiter will still persist; and if there is reason to remove nodular goiters without symptoms, there is greater reason to excise those associated with thyrotoxic manifestations.

The preferred treatment, *preoperative management and subtotal thyroidectomy* has also undergone modification in recent years. In addition to iodine (Lugol's solution) for preparing the patient for operation, we now have at our disposal a number of the antithyroid drugs. What are the relative merits and disadvantages of both agents, and when should either be used? Iodine has three real advantages over other drugs; it is safe, it acts rapidly, and it produces an anatomical involution of the gland which makes for technical ease of handling at the operation. It has one great disadvantage as compared to the newer drugs, i.e., it produces only a partial remission of the hyperthyroidism. While this is of little concern in very mild and border-line hyperthyroidism, it is important in the severe and moderately severe cases where surgery must still be done in the presence of material degrees of hyperthyroidism, and the risks of thyroid crisis or of excessive tachycardia still constitute real hazards.

The antithyroid drugs, of which propylthiouracil is the most familiar, have three disadvantages. They are all toxic to various degrees, and side-effects have occurred with all. The most serious of these are neutropenias which, if unrecognized, may be fatal. A death from toxic hepatitis has also been recently reported. If used, these drugs must be given with caution, with periodic examinations for possible reactions. Some of the newer agents are effective in much smaller doses than is propylthiouracil, and are proportionately less toxic.

There are two other disadvantages to the antithyroid drugs. They are slower in their action, and they produce an anatomical hyperplasia of the thyroid gland. This latter effect makes for extreme vascularity, friability and difficulty in operative manipulation. These changes can be obviated by discontinuing the drug seven to ten days before the anticipated operation, and substituting Lugol's solution in full doses for that period of time.

The greatest advantage of the antithyroid drugs, which vastly outweighs the objections to their use, is that they are capable of producing a complete remission of all the manifestations of hyperthyroidism. With judicious administration, virtually every hyperthyroid patient can be brought to operation in a euthyroid state, with a normal metabolism and pulse rate, and safe from the dangers of postoperative crises.

SUMMARY

The thyroid picture has undergone dramatic changes in the past two decades. Simple nodular goiters are being removed far more frequently than was the case during the height of goiter endemnicity, because of fear of carcinoma. This fear has been vastly exaggerated. The indications for removal of non-toxic nodular goiters have been enumerated.

In the management of hyperthyroidism, preoperative preparation and subtotal thyroidectomy continue to be the method of choice. The relative values of medical treatment with antithyroid drugs and irradiation with radioactive iodine have been described. The merits and disadvantages of iodine and antithyroid drugs in preoperative preparation have been compared. With proper selection of therapeutic methods, the results are excellent and the mortality rate is very low.

The Importance of Electrolytes in Various Cardiac Conditions

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The history of the understanding of congestive heart failure has gone through three phases. Mackenzie assumed that when the heart failed, there was a failure of the pump, in that symptoms of heart failure were due to an inadequate supply of blood to the tissues. Such individual symptoms as dyspnea were explained on the basis of an inadequate supply of blood to the respiratory center of the brain; edema was considered to be due to an anoxia of blood vessels with leakage of fluid through their walls[1].

It was soon determined by Starling[2] and others that forward failure as described by Sir James Mackenzie was insufficient to explain all of the symptoms of heart failure. On the basis of experimental work, they suggested that congestive heart failure was due to back pressure behind a diseased chamber of the heart. Because of failure of this chamber, blood would dam up behind it in the veins. The immediate secondary effect was to increase venous pressure, which then produced transudation into tissues. By means of this conception, dyspnea is explained as being due to congestion in the lung with a resultant decrease in vital capacity; and edema is explained as being due to increased venous pressure, and therefore, increased hydrostatic pressure within the veins, which forces fluid from the blood into the subcutaneous tissues.

Recently, Warren and Stead[3] and Merrill[4] and others have revived the idea of forward failure. They have been able to show that in certain cases, salt and water retention in the body tissues precedes the development of an elevated venous pressure. They have also attempted to show that in heart failure there is an almost constant decrease in the amount of blood that the heart can expel from its chambers (reduced cardiac output). They have also been able to show that when there is a reduction in cardiac output, the renal blood flow was more markedly reduced than flow to other vital organs. It has also been demonstrated that there is a marked correlation between the amount of edema and the intake of salt, the sodium of the salt being the active factor.

On the basis of these findings, they suggest that congestive heart failure is initiated by a decreased cardiac output which leads to first, a retention of sodium by the kidney because of decreased blood flow to the kidney; and secondarily, increase in the fluid component of the blood (hypervolemia), following which transudation and edema occur. They therefore predicate the primary importance of sodium balance in producing symptoms of heart failure.

The literature is replete with the results of experimental work tending to prove one or the other theory. The question still remains unresolved.

Electrolyte imbalance plays a role not only in the precipitation of heart failure, but may be the cause of various symptoms in heart failure. The importance of limiting salt intake is well understood, but the possibility of producing harmful and even fatal symptoms because of extreme sodium deprivation is less well known. Schroeder[5] has best described the production of the *low salt syndrome*. When the patient is deprived of sodium in his diet and is, at the same time, stimulated to lose sodium in his urine by means of mercurial diuretics, dehydration ensues even though occasionally there is paradoxically a retention of subcutaneous edema fluid. Urinary volume is diminished and nitrogen retention occurs. The patient may die from uremia. In fact, 11 of 21 patients described by Schroeder did die. Clinically, the syndrome may be suspected if, while under rigorous treatment of con-

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gestive failure, the patient complains of muscular cramps, sleepiness, and decreased urinary output. Blood chemistry studies and determinations of the urea nitrogen, creatinine, chlorides, and sodium will confirm the diagnosis.

Electrolyte imbalance in the treatment of heart failure not uncommonly is produced by the too vigorous use of ammonium chloride. In these cases, an excess of chloride produces, particularly in patients with minor degrees of kidney damage, a chloride acidosis. Acidosis in such cases may be productive of symptoms, particularly dyspnea. Chloride acidosis should be watched for and prevented.

Acute myocardial infarction, because of the shock state not uncommonly associated with it, produces some degree of renal dysfunction. This syndrome has been incorrectly labelled, "the lower nephron syndrome."[6,7] Basically, what seems to happen is true forward failure in the sense that hypotension and certain other factors produce a decrease in the renal blood flow with retention of nitrogen products and various electrolytes, particularly sodium, chloride, and potassium. Occasionally, death in acute myocardial infarction may be due not to the cardiac involvement, but to the secondary damage done to the kidney, which results in uremia.

Conclusions.—In contrast with studies in heart disease before 1930, later studies have emphasized the importance of electrolyte imbalance in 1. the onset of heart failure; 2. in complications of heart failure; and 3. arising as the results of the treatment of heart failure.

SUMMARY

1. The theories of heart failure as a result of "backward" and of "forwad failure" have been discussed.

2. The primacy of salt retention in the forward failure theory has been emphasized.

3. The relationship of electrolyte imbalance to various cardiac states has been stated.

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Principles of Drug Therapy in Hypertension

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The discussion of principles of drug therapy in hypertension — today's topic — is a discussion of hypertension rather than drugs. If the etiology of hypertension has been clarified, the selection of the proper drugs for its treatment will follow naturally.

The authorities on hypertension are committed to many "causes". Some feel that hypertension is neurogenic; that it might be caused, for instance, by some pathology of the central nervous system involving the "Buffer Nerves". Yet, when we examine the carotid sinus reflexes we cannot find any alteration of the basic carotid sinus response: it behaves as expected if one considers the level of pressure to which it is subjected. It is true that a "carotid sinus hypertension" has been produced experimentally in dogs, but we doubt that a similar mechanism can be held responsible for hypertension in man.

Of other possible causes for hypertension, the "nephrogenic mechanism" has probably had the most persistent appeal. Without question, the kidney is or becomes involved in high blood pressure and Goldblatt's restraining bands have indeed caused chronic hypertension. In man, however, the last word has yet to be spoken: which kidney lesions are cause of hypertension, which are effect.

Endocrine disturbances of various types are known to be accompanied by hypertension, and the adrenal cortex has been singled out lately for a great deal of attention. In pheochromocytoma the medulla and its production of noradrenalin seems to be incriminated in the etiology of the vascular changes. Of the adrenocortical hormones, desoxycorticosterone acetate — DOCA — seems to be the most active hypertensive agent, while cortisone or Compound F have a doubtful effect on vascular regulations. It seems conceivable that an electrolyte disturbance, mediated through the adrenal cortex, might in the final analysis be responsible: we have been able in my laboratory to produce hypertension in the chicken by salt and DOCA. Since any research evidence should produce some counter evidence, I must mention that the experimental hypertension in dogs can disappear without change in salt balance, but I always feel that the salt balance in dogs is not as sensitive as in other species as far as hypertension is concerned.

Some pituitary hormones have a very definite hypertensive effect which can be observed clinically in acromegaly and Cushing's syndrome, and it is well-known, of course, that the posterior pituitary hormone, pitressin, is a very effective pressor substance.

My purpose in listing a few of the possible reasons for hypertension is obvious: I believe that there is not one cause, but a multiplicity of causes. In most of our patients we are uncertain even about the predominant factor: we simply speculate about the possible etiology. In other words, we cannot expect to find a specific treatment for hypertension until we know more about its specific etiology. Rather we treat, nonspecifically, the changes which are the common denominator of hypertension, whatever its specific causes might be, namely, the increase in the pressure itself and its immediate effects.

Hypertension is the result of increased resistance in the vascular tree. We used to think

that the vasoconstriction of the splanchnic vessels might explain the increase in resistance, but we have come to realize that the systemic circuit consists of a series of parallel systems — resistance in all of the systems must be increased before generalized hypertension can develop. It is interesting that Basett has calculated that the caliber of the systemic vessels (provided all are involved) has to change by only one-tenth to double the resistance in the systemic circuit. Even in rather severe hypertension some vascular areas seem to be exempt from the otherwise generalized increase in pressure: as a rule the pressure in the pulmonary circuit remains unchanged and there is no evidence that the portal pressure is altered in hypertension. In most instances hypertensive patients have a normal cardiac output and the circulating blood volume remains unchanged in the absence of congestive failure. Most of us have treated at least some hypertensive patients who, after some twenty years of hypertension, showed no other abnormalities than a mild enlargement of the heart and some strain reflected in the electrocardiogram.

If hypertension is caused by elevation of peripheral resistance, one wonders about the mechanism which might be responsible for producing it. Some authors hold that the muscular hypertrophy which is the result of the poor nourishment of the muscular tissue in hypertension might in turn cause irreversible anatomical changes. It has always been difficult, of course, to judge which of the changes observed in hypertension are primary and which secondary. For many years I have called attention to the alteration in the blood flow which occurs in hypertension before the capillaries show demonstrable changes. Yet, while the renal circulation is often decreased, the coronary blood flow must be increased. Moreover, the decrease of the blood flow in the renal circuit, for instance in Goldblatt's hypertension, is reversible. Our own studies leave no doubt that pyrogens are able to enhance renal blood flow and return the blood pressure to normal levels. We are unable even to guess at the mechanism of the reversal. Let me remind you, that Eugene Stead expressed the thought many years ago that hypertension might not be caused by either vasoconstriction or altered blood flow, but that it might be the result of changes in the vascular wall associated with unknown errors in salt and water metabolism. Our own findings on the effect of salt on hypertension in the chicken has given new significance to Stead's suggestions. If changes of this type take place in the arteriolar wall, they might very well cause an increase in the total peripheral resistance.

Up to this point I have tried to emphasize the fact that there is more than one approach to the problem of hypertension; but that in spite of it we are still in the dark about its etiology in man. What then is the rationale of treatment at the present state of our knowledge?

For many years, as you probably know, I have questioned the reasons for even trying to reduce blood pressure. I have changed my mind about this point in the light of our recent studies. Chickens in which experimental hypertension is produced with salt and desoxycorticosterone acetate developed a greater number of atheromatous lesions in the cornonary artery and aorta following cholesterol feeding than did the controls. Independently Wakerlin and his collaborators showed a similar effect in nephrogenic hypertension in the dog. Preceding our own experiments, Waters at Yale has shown conclusively in rabbits that hypertension aggravates existing vascular changes. Philosophically, one might reason that the reaction of the vascular wall might represent the defense of the body against hypertension. Clinically, however, the same lesions are largely responsible for the morbidity and mortality in hypertension. Coronary disease and cerebral vascular lesions are aggravated by hypertension. One must also consider that hypertension might, but need not, lead to hypertensive heart disease.

Treatment of hypertension requires treatment of the patient as a whole. Statistically, a young female suffering from hypertension has a good chance to live a long and approximately normal life. Men who are fat and forty, or more, on the other hand, are patients with a guarded prognosis. In treating hypertension one must treat as many etiologic factors as possible, real or suspected: this might include diet, in a non-specific or perhaps specific fashion (the role of cholesterol still awaits further clarification), and psychosomatic mechanisms. The patient who worries about heart attacks and sudden death must be taught to look at his hypertension with common sense and equanimity. The low-

ering of the blood pressure invites some dangers: for instance, in induced insufficiency of coronary blood flow, renal insufficiency, or cerebral ischemia. In other words, we have to be certain of an adequate renal and cardiac reserve before we institute therapy.

While I am in favor of decreasing blood pressure in hypertensive patients, I am uncertain how it should be accomplished. None of the drugs which are now available is "ideal." Thiocyanates are of doubtful value and on occasion produce serious reactions. Veratrum and pro-veratrum lower blood pressure effectively in animals, but are not as predictable, I believe, in man. Hexamethonium and apresoline are effective hypotensive drugs, but must be given under close supervision. Dibenamine has its specific, yet limited, place. Dr. Wakerlin's renin bears promise, but is still on trial.

In patients who have hypertension of adrenergic origin, sympathectomy might be the therapy of choice. Sympathectomy has lowered hypertension in a sufficient number of patients, to a sufficient degree, for a sufficient length of time, to consider it a safe, if not always successful, procedure. If effective, it operates twenty-four hours a day: this is an advantage and disadvantage at the same time. Drugs can be started and withdrawn, but surgery is irreversible. During the summer Perera of New York and I attended a caucus on malignant hypertension in a "smoke-filled room" with Fasciola, Braun-Menendez, Taquini and Lequime in Buenos Aires. We discussed every phase of the subject including the development and significance of nephrosclerosis. It was the consensus of the group that an adrenergic factor must be implicated in the etiology of the malignant phase of the disease; that treatment accordingly should be directed toward sympathicolysis at this stage: many of those present felt that sympathicolysis was a primary objective and that the fall in blood pressure was almost coincidental. A sound experimental basis for these concepts is lacking, but I was impressed by the clinical evidence which had been gathered by the discussants. It should be accepted, I believe, as a working hypothesis for future studies.

In summary, I have tried to make three major points:

1. At this time we are still in the dark concerning the etiology of hypertension in man and must strive to clarify it.

2. High blood pressure should be reduced. Of several possible ways to reduce it, none is ideal: treatment must be adapted to the individual.

3. In malignant hypertension, sympathicolysis is probably the most important therapeutic objective.

DISCUSSION

Dr. George E. Wakerlin, Professor of Physiology: Hypertension, as you know, is close to my heart; I have talked a great deal about the subject and I have heard a good many other people talk about it. I would like to state that this is the best summary of our present state of knowledge which I have heard. Sometimes I disagree with Dr. Katz; today I cannot find a single point of disagreement. In fact, I would have liked to have said myself some of the things which he has said.

It is important to emphasize the basic truth which Dr. Katz has emphasized — that further research on the pathogenesis of hypertension must go on before any specific therapy can be established. The kidney, the adrenal cortex, and the nervous system have been implicated in the pathogenesis of the disease. It seems entirely possible that it may start in any one of these three areas and from there spread to the others. I cannot help believing that hypertension is an entity with multiple manifestations.

I don't think that one can be cautious enough against the indiscriminate use of hypotensive drugs. Rapid reduction of blood pressure is dangerous. One must be careful and patients so treated must be under continuous and vigilant control.

One final remark: It makes me very happy to learn from Dr. Katz's experience in the Argentine that sometimes at least some good ideas can come out of smoke-filled rooms.

Dr. Ford K. Hick, Professor of Medicine: You mention changes in salt and water metabolism as one of the possible causes of hypertension. Would you care to comment on the rationale of salt restriction in the treatment of hypertension?

Dr. Katz: It is not easy to evaluate the effectiveness of any therapy in the treatment of hypertension and, by the way, hospitals, not laboratories, are the final proving grounds for concepts developed in laboratories. It is probably safe to say that about one in ten hypertensive patients will benefit from a low salt diet;

and the Kempner diet is of course a modification of the low salt principle. In general, obese patients of the pseudo-Cushing syndrome type give the most encouraging response to salt withdrawal. I am not talking about those patients, of course, whose hypertension is complicated by congestive failure.

Dr. Louis Johnston, Research Assistant in Medicine: Dou you find renal changes in your chickens with salt-hypertension?

Dr. Katz: Yes.

A Physician: How do you explain the absence of hypertension in patients with syphilis and rickettsia infection on one hand, on the other hand, its fairly common presence in poliomyelitis?

Dr. Katz: I am not certain that vascular syphilis and hypertension are mutually exclusive. I have seen the combination in several of our patients. I lack experience about the blood pressure in rickettsia infections and do not feel qualified to make any comments. Poliomyelitis presents an interesting problem because the occurrence of hypertension in bulbar polio seems to provide a clue of a neurogenic vs. a nephrogenic etiology of the syndrome. Unfortunately, one such patient under our observation, who had never been previously suspected of hypertensive disease, had renal changes and therefore did not contribute any acceptable evidence for or against either concept.

A Physician: On reading EKG's or, as you prefer, ECG's do you differentiate between left heart strain and left ventricular hypertrophy?

Dr. Katz: It seems logical to me, and indeed I insist on saying "ECG" since we speak English, not German, in our professional communications. Strain — the term did not originate with me, by the way, it was coined by Barnes — differs from hypertrophy, and the "strain pattern" of the S-T and T waves might quickly disappear following the use of hypotensive drugs or sympathectomy, while the electrocardiographic evidence of hypertrophy will of course persist.

Dr. Melvin M. Chertack, Clinical Instructor in Medicine: Would you add phenobarbital to your list of drugs used in hypertension?

Dr. Katz: Sedation is probably the most important therapeutic objective in hypertension. The patient needs serenity in his everyday life; it does not matter much how it is acquired. Alcohol, barbiturates, a heart-to-heart talk in a physician's office, and rarely, even psychotherapy, might be indicated. Personally, I doubt that even intensive psychotherapy will affect essential hypertension more than temporarily.

A Physician: What are your criteria for starting therapy in patients who have an increase in blood pressure?

Dr. Katz: Standards are variable, of course. I am inclined to agree with Master, for instance, that the upper limits of normal blood pressure are too low. Clinically, I would say that the diastolic pressure is a more reliable guide than the systolic pressure. Diastolic pressure of or near 100 would cause me some concern; a diastolic pressure of 120 would make me wish to act. Let me conclude with a final word about statistics. Statistics are essential for those who deal with large numbers, for the chemists and physicists who deal with myriads of molecules, and even for research workers who evaluate large series of fairly comparable animals. Decisions must be different for the clinician, because in the last analysis each of his hypertensive patients might defy the laws of statistics; in other words, each patient must be considered regardless of systolic or diastolic levels in the light of his own individual makeup and circumstance.

CASE REPORTS



Treatment of Anterior Laryngeal Stenosis by Tantalum Plate Implant

Albert H. Andrews, Jr., M.D. and Marvin J. Tamari, M.D.
Chicago

Anterior stenosis of the larynx whether due to a congenital web or due to an acquired adhesion between the vocal cords has presented therapeutic problems to which, so far, there has not been a completely satisfactory answer. Mc Naught[1] has described a method of surgical treatment which consists of incising the stenosis and placing a thin tantalum plate between the vocal cords through the inferior two-thirds of the thyroid cartilages. It is the purpose of this paper to discuss alterations in the technique of this operation, and to present a patient so treated.

The principal methods of treatment of stenosis of the larynx due to an anterior adhesion of the vocal cords are as follows:

1. Laryngeal dilatation.
2. Incision of the web or cicatrix followed, if necessary, by dilatation.
3. Excision of scar tissue.
4. Excision of scar tissue and application of a skin graft over a sponge, hard rubber, or acrylic mold.
5. Incision and placement of a silver plate between the vocal cords.

Mc Naught has described a procedure which includes some of the favorable features of the above methods of treatment and consists of the placement of a tantalum plate through the inferior two-thirds of the thyroid cartilages, and between the vocal cords after incision of the adhesion.

Patient, J.S., I.E.E.I., #55548, Negro, Male. Admitted June 7, 1950. Referred by the Elgin State Hospital. In 1948, his neck was cut in a transverse direction and an emergency tracheotomy was done at the Cook County Hospital.

From the Illinois Eye and Ear Infirmary, Department of Otolaryngology, University of Illinois, College of Medicine, Chicago, Illinois.

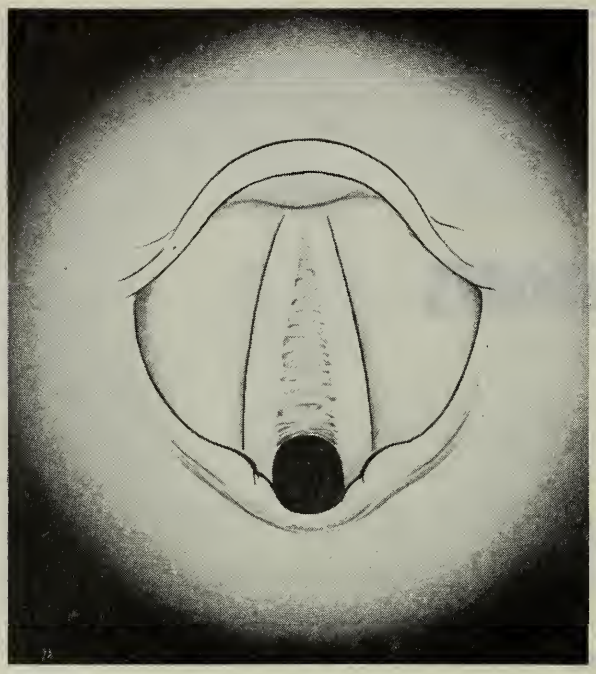


Figure 1.—Diagramatic representation of the anterior laryngeal stenosis.

He was transferred to Veteran's Administration Hospital, Chicago, where dilatations were done. Scar tissue was excised, and a skin graft applied. The tracheotomy tube was subsequently removed.

On admission to the Infirmary, there was an adhesion between the vocal cords in the anterior two-thirds of the larynx and limitations of abduction of both arytenoids. (Figure 1) Because of increasing dyspnea, another tracheotomy, was done. At direct laryngoscopy, under local anesthesia and crurare, the adhesion was incised. Subsequent dilatations failed to prevent rapid recurrence of the adhesion. Crurare or general anesthesia was required for each direct laryngoscopy so that a series of dilatations was not feasible. Therefore, external surgery was contemplated. In view of the previous failure of the more conventional surgery of excision of the scar and skin graft, the case was considered suitable for the operation described by Mc Naught.

On November 16, 1950, under general anesthesia and through a horizontal incision at the level of the cricothyroid membrane, the thyroid cartilage was exposed in the midline. Using a motor driven saw, a cut was made in the midline through the inferior two-thirds of the thyroid cartilage. Direct laryngoscopy was performed by Dr. E. M. Skolnik, and the adhesion

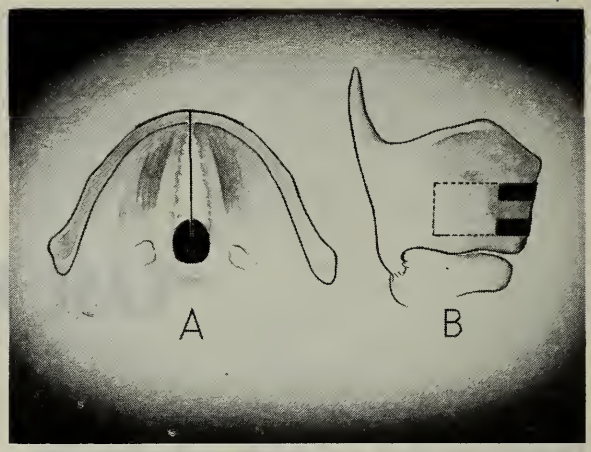


Figure 2.—Diagramatic representation of the tantalum implant. A. Transverse sectional view of larynx showing plate between cords and tabs on external surfaces of thyroid cartilages. B. Lateral view of larynx showing external tabs and tantalum plate (dotted lines) inside of larynx.

between the cords was incised under combined laryngoscopic and external visualization. Sheet tantalum 0.007 inches thick was cut to fit into the larynx, and to extend about two-thirds of the distance back to the interarytenoid area. Cuts were made into the tantalum so that tabs could be turned down, one on one side, and two on the other. The strap muscles were sutured together in the midline over the tabs, and the skin closed. (Figures 2 & 3)

There was improvement in the breathing after the operation for about a month and the patient kept the tracheotomy tube plugged. Because of

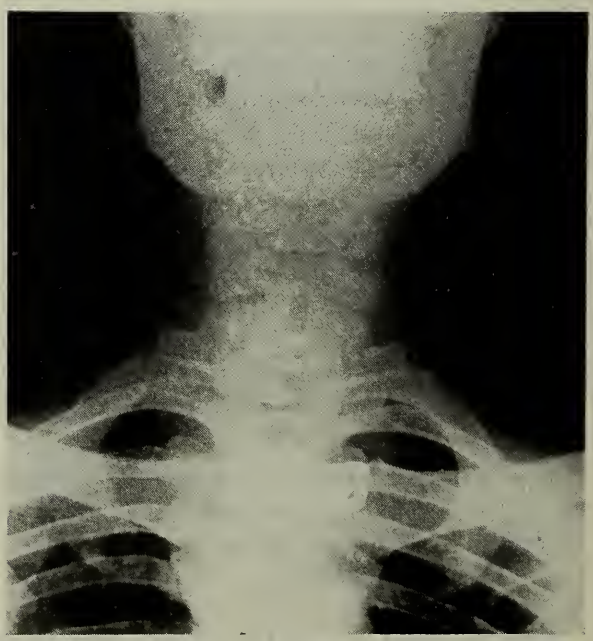


Figure 3.—Anterior-posterior roentgenogram showing tantalum plate in larynx.

the angle of the plate, it was thought that there might be recurrence of the stenosis below the plate. A laryngogram was done by instilling lipiodol into the larynx, and showed an area of stenosis just inferior to the plate.

Using the lateral x-ray of the neck, the proper shaped implant was designed, and cut out of aluminum foil and was intended as a pattern for the preparation of a more satisfactory implant. It was noted that the anterior edge of the thyroid cartilages was at a considerable angle to the long axis of the larynx, and that this resulted in the implant being inclined upwards and above the stenosis in its posterior part.

On February 22, 1951, and under general anesthesia with pentothal and crurare, the wound was reopened and the tantalum removed. A new implant was prepared from the pattern, and was trimmed down to fit. A notch was cut in the upper part so that the implant would not have a tendency to rotate.

The patient's breathing and voice immediately improved following this operation, and after a few days, the tracheotomy tube was plugged most of the time. On April 27, 1951, approximately two months after the placement of the implant, it was removed under general anesthesia. Because of poor viability of the tissues, and the large scar present, this was done through a vertical incision.

His condition at the present time is good, and there is an adequate lumen. There appears to be complete epithelialization of the vocal cords without recurrence of the adhesion. An arytenoidectomy and arytenoid transplant may have to be considered.



Figure 4.—Right lateral roentgenogram showing tantalum plate in larynx.

DISCUSSION

After incision of a cicatrix or web between the vocal cords, recurrence starts at the extreme anterior part and proceeds posteriorly to the epithelialized area of the cords. The tantalum plate prevents this recurrence and allows epithelialization to proceed. The tantalum is inert and produces minimum reaction in the larynx. The method of fixation of the plate to the larynx allows the free movement of the plate with the larynx and reduces mechanical irritation. The bridge of intact cartilage superiorly maintains the normal relation of each thyroid cartilage and prevents the abnormal movements which would occur if the thyroid cartilages were completely severed. Le Jeunne has reported the use of this method in the removal of carcinomas by the thyrotomy approach. He stated that the method prevented scar tissue from forming across the anterior portion of the larynx and prevented subsequent respiratory obstruction. This would seem to indicate that the bridge of cartilage is not essential. However, it does appear to be a valuable point in the technic, and one that does not interfere significantly with the technical aspects of the procedure.

A two month period is thought to be sufficient for the epithelialization to occur and in this case, the plate was well tolerated for a longer period.

At the initial operation, the plate was placed at nearly a right angle to the anterior surface of the thyroid cartilage. This surface usually slants forward at an angle of about 20° to 25° to the vertical axis of the larynx as judged by the posterior borders of the thyroid cartilages. In this patient, the angle is about 40°, and consequently, the plate was too high at it's posterior end. The lateral roentgenogram of the neck exposed for the larynx, and taken at two meter distance, demonstrated this angle. A pattern was cut out of aluminum foil, so it could be easily sterilized, and simplified the design of the plate at the second operation.

SUMMARY

1. Mc Naught has described an operation for anterior stenosis of the larynx which consists of the placement of a thin tantalum plate through the inferior two-thirds of the thyroid cartilage and the incised stenosis. The plate is held in place by tabs bent down on each side.

2. A case is reported in which this operation was used, and the importance is stressed of a pattern made from the lateral x-ray of the neck and the correction for the angulation between the anterior surface of the thyroid cartilage and the vertical axis of the larynx.

3. This procedure prevents recurrence of the stenosis and allows epithelialization of the vocal cords to proceed.

4. It appears to be a valuable adjunct to the surgical treatment of laryngeal stenosis.

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Since presentation of this paper, the tracheotomy tube has been removed, and the airway has remained adequate. The voice is rough but improved over the condition prior to surgery. The vocal cords are epithelialized and there has been no suggestion of recurrence.

RESINS

Cation-exchange resins (Resodec) are effective adjuncts to diets low in sodium content but are not substitutes for them in the management of properly selected patients suffering from essential hypertension. With the resins, diets containing 1.0 to 1.25 gm. sodium can be utilized instead of the levels of 0.2 to 0.5 gm. needed with dietotherapy alone. Thus, dietary palatability and patient co-operation are increased. Deficiencies in serum calcium and potassium, which sometimes occur as the result of this therapy, may be prevented by the administration of supplements of calcium lactate and potassium citrate. This measure also serves to minimize the tendency to hyperchloremic acidosis. These studies strengthen the claims of those who believe that the reduction of sodium has an important place in the treatment of essential hypertension. The easier and more intense sodium restriction attained by the sodium-removing properties of the cation-exchange resins increases greatly the number of non-hospitalized patients with hypertension who may be benefited. The dramatic benefit from cation-exchange resin therapy in patients whose hypertension had not responded adequately to sympathectomy is recorded. It is suggested that the addition of such therapy to the restriction of sodium may salvage a considerable percentage of these patients with intractable hypertension. A trial of cation-exchange resin and restricted dietary sodium therapy may safely be given to a patient with essential hypertension if he has at least moderately good renal function as indicated by urinalysis, the phenolsulfonphthalein excretion test or urine concentration test, and the blood urea nitrogen determination. *Robert J. Gill, M.D. and Garfield G. Duncan, M.D., Arterial Hypertension — The Therapeutic Effect of Cation-Exchange Resins. New Eng. J. Med. Aug. 21, 1952.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Primary Amyloidosis of the Heart, Kidneys and Other Viscera

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Systemic amyloidosis occurs in two forms, the secondary or typical and the primary or atypical. The secondary form of amyloidosis is associated with a chronic granuloma such as tuberculosis, a chronic suppurative process such as chronic osteomyelitis, a chronic debilitating cancerous disease, or certain tumors of the bone especially the multiple myeloma. The primary form has no associated disease process and seems to arise spontaneously.

The amyloid infiltrations in the secondary or typical form of the disease are into the spleen, the liver, the lymph nodes, the kidneys and the suprarenal glands. In the primary or atypical form, the deposits are in a single location such as the tongue, the larynx, the trachea, the myocardium and many other tissues, but mainly sparing the organs involved in the secondary form. This distinction cannot be made invariably. Lubarsch formulated the following criteria to distinguish the primary form of amyloidosis from the secondary: 1) absence of a predisposing factor such as a chronic suppuration; 2) failure of the amyloid deposits to give the specific straining reactions; 3 absence of involvement of the viscera commonly affected in secondary amyloidosis; and 4) extensive deposition of amyloid in tissues such as the heart, the blood vessels, the skin and the skeletal muscles not commonly involved in secondary amyloidosis. The distribution of the amyloid deposits alone, however, does not differentiate the primary from the secondary form of the disorder.

The amyloid, at first regarded as carbohydrate, is now considered to be abnormal coagulable proteins or protein-like substances deposited in the tissue spaces of the wall or adjacent tissues of blood vessels. Widespread deposits of amyloid can

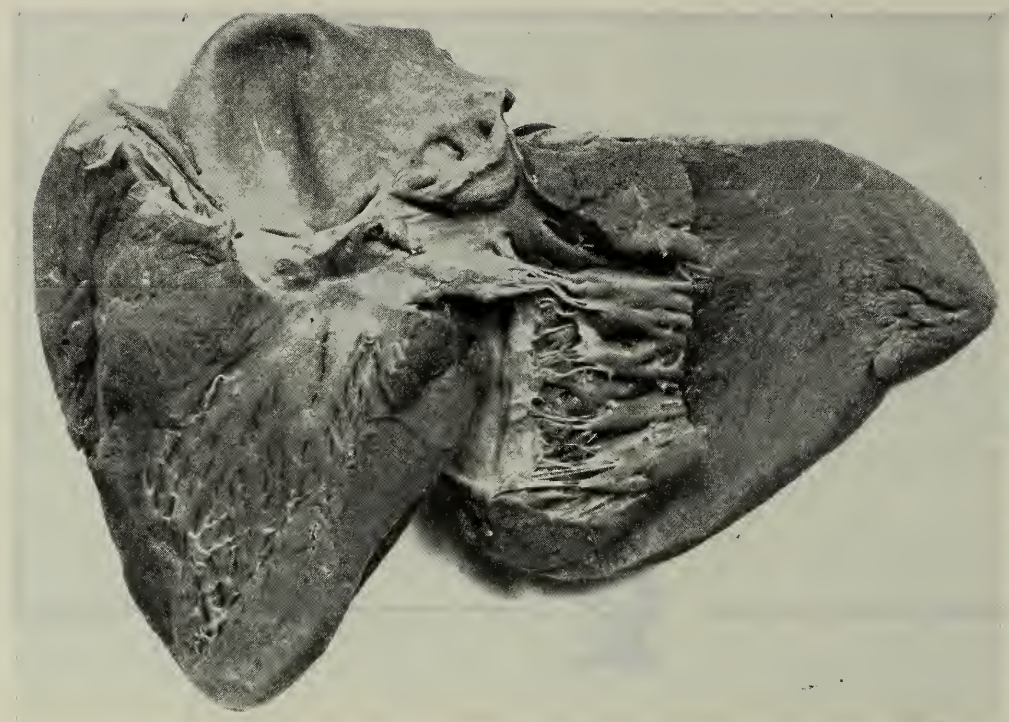


Figure 1. Photograph illustrating the anomalous calcified bicuspid aortic valve and the small focal fibrous scars and amyloid deposits in the myocardium of the heart.

be produced experimentally in the tissues of mice by injections of sodium caseinate. Amyloid deposits in the tissues have certain, but not invariably specific, staining qualities. According to a report by Hartney, Bunderman, Blumberg and Leedham in 1949 (Arch. Path. 47: 589, 1949) approximately 50 cases of primary systemic amyloidosis had been reported at that time. The heart frequently is involved in primary amyloidosis. Sometimes cardiac failure results therefrom. According to Lindsay (Am. Heart J. 32:419, 1946) this may be due to 1) involvement of the pulmonary vessels and alveolar walls of the lungs to produce a chronic cor pulmonale, 2) amyloidosis of the coronary arteries with coronary insufficiency or infarction, 3) amyloid infiltration of the interstitial tissues of the myocardium with or without atrophy of the muscle fibers, 4) deposition of amyloid in the pericardium or endocardium, 5) amyloid involvement of cardiac valves with stenosis or insufficiency, or 6) combinations of these factors.

An example of primary amyloidosis with involvement of the heart and blood vessels and with unusual changes of the kidneys was observed in a white male, aged 63 years, who entered St. Luke's Hospital on May 16, 1952 in the care of Doctor Carl A. Johnson and died suddenly four days later. He had been in good health until the preceding November when he began to be dizzy with slight exertion, and in February while standing became dizzy and fainted. During the eight weeks prior to admission to the hospital he had approximately seven attacks of this kind, which lasted only a few minutes, and were associated with nausea and vomiting. At another hospital he was told that he had kidney and heart trouble and a low blood pressure. When admitted to St. Luke's Hospital his blood pressure was 120/80 mms. Hg.; his temperature was 99°F., his pulse and respirations were respectively 80 and 20 per minute. The heart was enlarged to the left and slightly to the right, had a marked systolic murmur at the apex and a lesser systolic murmur at the base. The liver extended below the costal arch. The blood had 4,390,000 erythrocytes and 8,400 leukocytes per cmm. and 12.0 gms. percent of hemoglobin. The sedimentation rate was 54 mms. in 60 minutes; the non-protein nitrogen of the blood was 57.5 mgms., the creatinine 2.9 mgms, the sugar 100 mgms. and the cholesterol 340 mgms. percent. The alkaline urine had a specific gravity of 1.007 and 250 mgms. percent of albumin. It contained a few hyaline casts and leukocytes. The specific gravity of the urine was fixed (1.006-1.005) in the



Figure 2. Photograph illustrating the focal ischemic atrophy of the capsular surface of the kidneys.

concentration and dilution tests. He died suddenly while in conversation with another patient.

The essential portions of the anatomic diagnosis of the complete necropsy are: congenital bicuspid valve and chronic fibrous aortic endocarditis — aortic stenosis; amyloidosis of the heart, spleen, and liver; bilateral focal cortical ischemic atrophy of the kidneys; chronic fibrous myocarditis and hypertrophy of the myocardium of the heart; atherosclerosis of the aorta; hypostatic hyperemia and edema of the lungs; right hydrothorax; etc.

The body weighed 135 pounds and in the peritoneum and in each pleural space was a small amount of clear limpid yellow fluid. Each lung was moderately expanded and hypostatically edematous and hyperemic, the right weighing 640 and the left 550 gms. The heart weighed 545 gms. (Figure 1). The lining of the right auricle and of its appendage was gray with fibrous tissue and the auricular surface of the tricuspid leaflets was granular with fibrous tissue. The circumference of the tricuspid ring was 12 cms. The leaflets of the pulmonary artery were thin, the circumference of the pulmonic ring under slight tension was 8.5 cms. The chambers of the left side of the heart were dilated. The lining of the left auricle and left auricular appendage was gray with fibrous tissue, the anterior mitral leaflet had moderate fibrous and fatty changes. The circumference of the mitral ring under slight tension was 11 cms. The length of the left ventricle from the mitral ring to the apex was 9 cms. and from the attachment of the aortic leaflets to the apex was 10 cms. The commissure between the right and the posterior cusps was fused, the aortic valve thus being a two-cusp structure, with an irregular slit-like opening 2 cms. long between the left cusp and the fused right and posterior cusps. The rigid fibrous leaflets were calcified. The mouth of each coronary artery was widely patent, and on the right side were two small accessory coronary arteries. The thickness of the myocardium along the septum in front and behind ranged between 1.5 and 2.4 cms. Many slate-gray regions, 2 to 4 mms. in dia., were visible under the endocardium of the right and left ventricles. Surfaces made by cutting the myocardium of the lateral wall and of the septum had dry brown fibrillar tissues streaked and mottled with blue-black regions several millimeters in dia. The lining of the coronary arter-



Figure 3. Photograph illustrating the focal regions of ischemic atrophy on surfaces made by hemisecting the kidneys.



Figure 4. Photograph illustrating amyloid deposits and focal encapsulated tubercles on surfaces made by cutting the spleen.

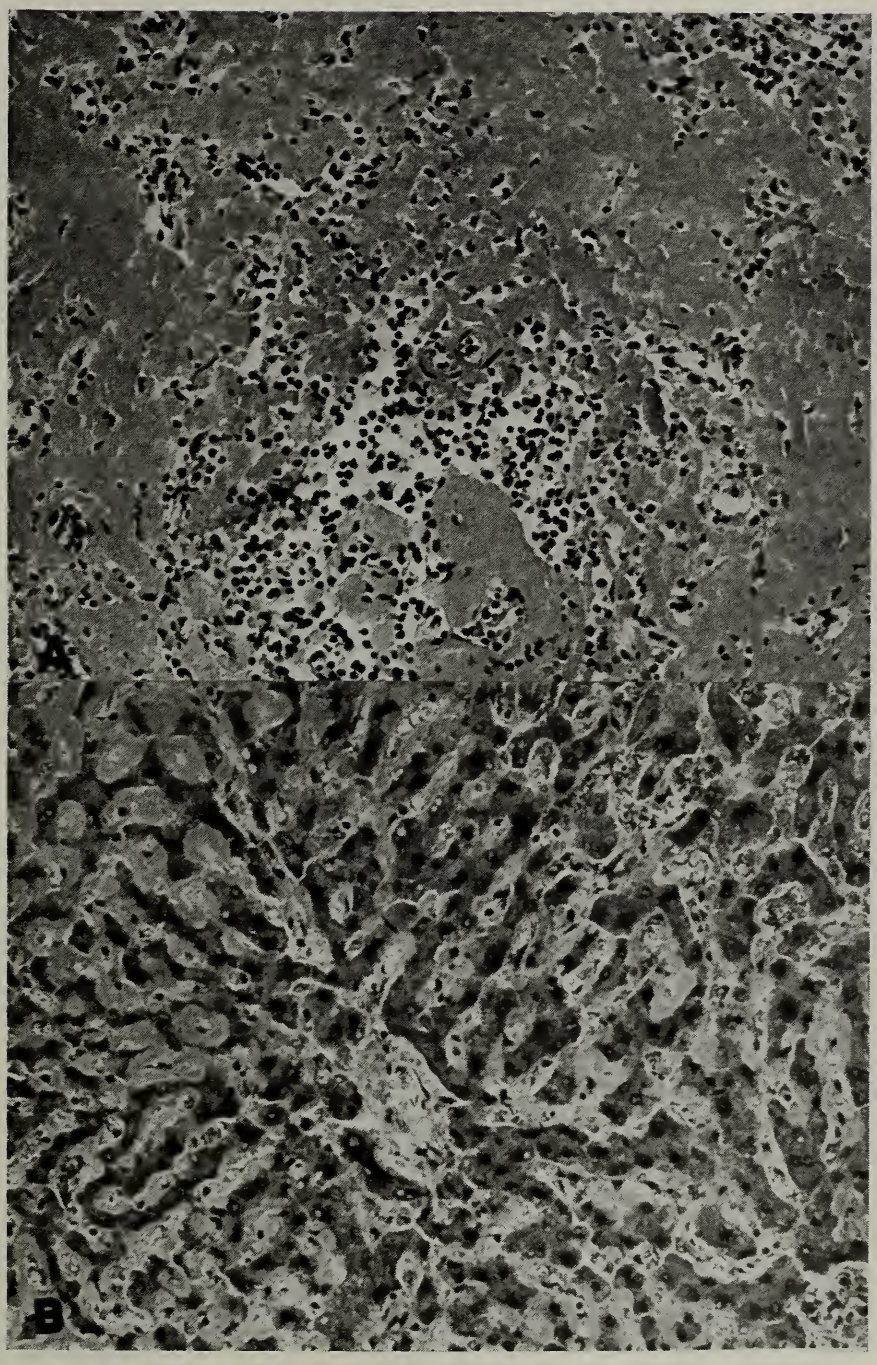


Figure 5. Photomicrographs illustrating amyloid deposits in (A) the spleen and in (B) the liver.

ies had moderate fibrous and fatty changes. The lining of the aorta had marked fatty and fibrous changes.

The firm and elastic right and left kidneys weighed 100 and 130 gms. The capsule of each stripped from a surface mottled gray-red and dark red (Figure 2). The gray-red portions were slightly elevated like plateaus, and ranged to 2 cms. in dia. They comprised about fifty percent of the surface and were elevated about 2 mms. above the surrounding dark red tissues. Their edges were rounded but not irregular. Surfaces made by hemisecting the kidneys from the convex edge to the pelvis (Figure 3) had wedges of gray-red tissues interspersed with the slightly depressed red-brown tissues. The cortical markings were indistinct and portions of the medulla were pale. The cortex in the depressed red-brown portions was about 4 mms. wide, in the gray-red elevated portions 7 mms. The spleen weighed 300 gms. and had a slate-gray tense capsule. The surfaces made by cutting were elastic red-brown and had islets of opaque or slightly translucent tissues 1 to 5 mms. in

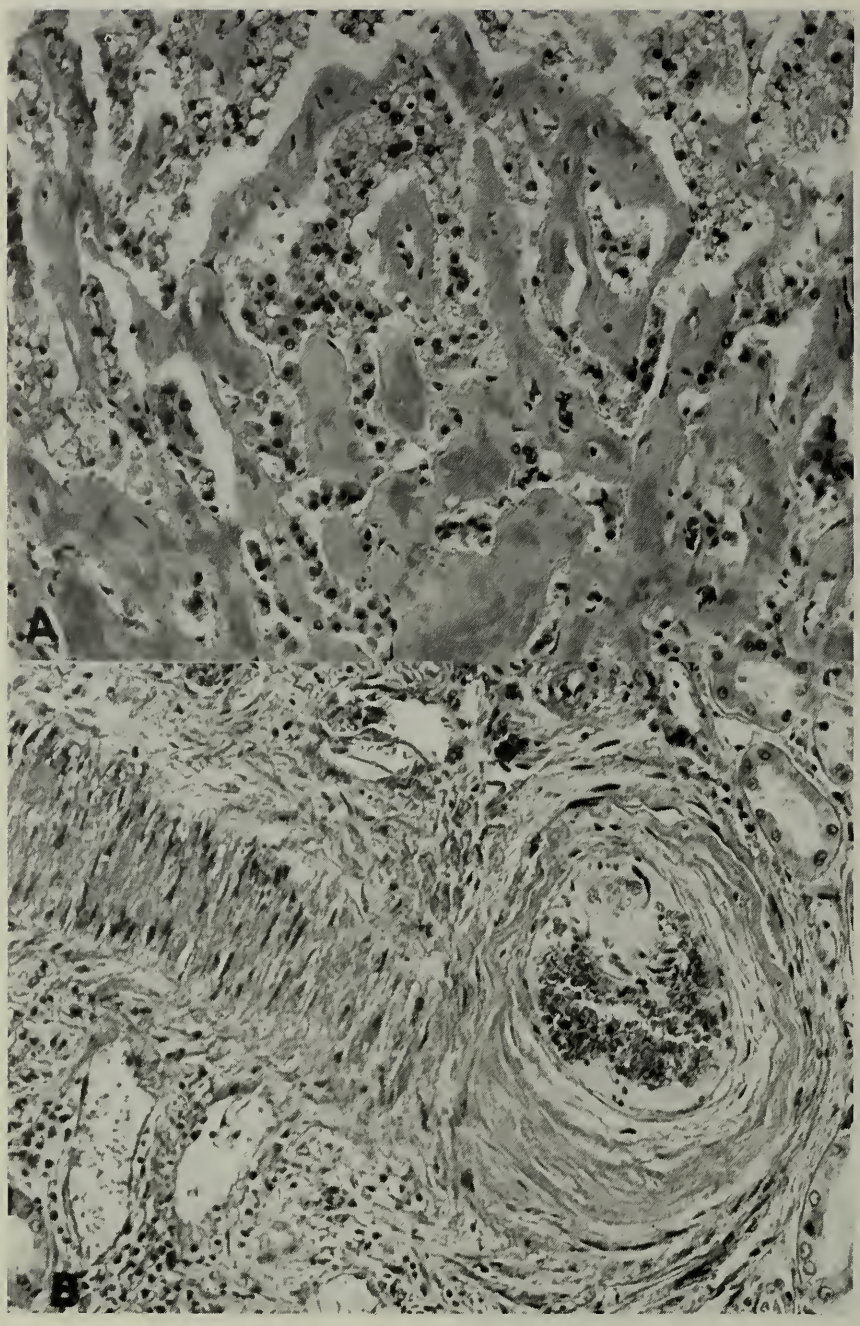


Figure 6. Photomicrograph illustrating in (A) amyloid deposits of the suprarenal glands and in (B) amyloid deposits in the wall of the interlobar branches of the renal artery with stenosis of the lumen and thrombosis.

dia. that comprised about 75 percent of the surface (Figure 4). A few solitary encapsulated tubercles 1 to 2 mms. in dia. were scattered in the splenic pulp. The firm, elastic liver weighed 1630 gms. The capsule was smooth and the tissues beneath had the usual lobular markings. Amyloid deposits were not grossly visible. The brain, other viscera and tissues had no significant changes.

Microscopic examination demonstrated large deposits of amyloid in the spleen (Figure 5A) and smaller deposits along the sinusoids of the liver (Figure 5B) and the suprarenal glands (Figure 6A), and the walls of the blood vessels in various parts of the body. Extensive portions of the myocardium had deposits of amyloid with replacement or atrophy of the myocardial fibers. The depressed regions of the kidneys were related with amyloid deposits and hyaline fibrous occlusions of the interlobar branches of the renal artery (Figure 6B). These regions had atrophy of the tubules, contraction of the glomeruli and lymphocytic infiltrations. The elevated portions of the cortex had renal tissues with much less of these changes.

COMMENT

Amyloid deposits of the myocardium cause forms of cardiac disfunction which are expressed, as Lindsay has mentioned, in a variety of clinical symptoms. Without some clue of the presence of an amyloid disease the clinician is certainly confronted with a diagnostic problem of cardiac pathology in his patient. In this case the attacks of syncopy and the sudden unexpected death of the patient are directly related to the myocardial damage associated with the deposition of amyloid in the heart muscle. The additional injury of the kidneys by the amyloid disease produced renal failure, clinically expressed by severe albuminuria and azotemia. The loss of renal function in these kidneys, however, resulted from amyloid deposits in the wall of the intrinsic branches of the renal artery, chiefly of the interlobar arteries with occlusion or stenosis of their lumens and focal ischemic atrophy of the parenchyma. This deposition in the wall of the renal arteries is in contrast with the more usual deposits of amyloid in the glomerular tufts which occurs in many kidneys with secondary amyloidosis and is expressed clinically as the amyloid form of nephrosis.

WHAT IS CANCER?

I submit that the neoplastic growth, the tumor, the cancer is an end product; that it is "the thing itself", and that not in a study of the thing itself will we find the answer to the enigma of its causation or the clew to its prevention or cure. I shall attempt to support this viewpoint in what follows.

Cancer is not repugnant to the body. Though we may diagnose cancer with sad dismay and regard the lesion with repugnance, the body does not at all share this attitude. On the contrary, it neither attempts to rid itself of the new growth nor shuns the responsibility for its support. An infectious process, a foreign body, or a bit of dead tissue not removable by phagocytosis (a sequestrum of bone, for example), is quickly walled off but cancer is not so treated. The cancerous growth is actually supplied with blood vessels of the body's own manufacture and the effort is always made, though ultimately it may fail, to keep the growing tumor fully supplied with blood. Work too — extra work — is done for it which may be demonstrated experimentally in both spontaneous and transplanted tumors in rats. In these animals there occurs hypertrophy of both heart and liver in reasonable proportion to the increase in the size of the neoplasm. And finally, the tumor may actually function and contribute physiologically to the body economy, though admittedly this is often above the requirements of the economy of the body as a whole. Adrenal pheochromocytoma and tumors of the islets of Langerhans in the pancreas, with their respective contributions of epinephrine and insulin, are examples. Definitely, cancer is not repugnant to the body. *Harry Beckman, M.D., Not in the Thing Itself. J. Kentucky M.A. Oct. 1952.*

COUNCIL MEETING MINUTES

Meeting of January 11, 1953

The regular January meeting of the Council was held at the Hotel Sherman, Chicago, January 11, 1953, with the following present: Sweeney, Lewis, Muller, Kirby, Camp, Lundholm, O'Neill, Stone, Oldfield, Vaughn, Reichert, Hesseltine, Hamilton, Hellmuth, Reisch, Blair, Newcomb, Goodyear, English, Montgomery, Fullerton, White, Hopkins, Coleman, Cross, Limarzi, George Turner, Van Dellen, Hoeltgen, Scatliff, Glenn Moore, Mr. Thomas A. Hendricks, M. P. Rogers, W. H. Palmer, W. K. Ford, Bruce Canfield, Mr. Douglas Thorsen, Neal, Leary and Frances Zimmer. Minutes of last meeting were approved by proper action.

CAMP referred to his report as sent to members before the meeting, and gave a short supplementary report, along with the report as treasurer. Referred to letter from the President of the Auxiliary asking the Council for the usual appropriation of $600.00 for their annual meeting. Motion (Lundholm-Vaughn) that this be allowed, and Secretary be instructed to send this amount to the treasurer of the Auxiliary about May 1. Motion carried.

SWEENEY reported as president, telling of meetings recently attended. Conducted the meeting of the Committee on Scientific Work, which made tentative plans for the 1953 annual meeting program. He was asked to represent the Society at a meeting of the American Medical Education Foundation scheduled for January 25, and appoint an official representative. Dr. Hedge will attend the meeting. Told of letters from Winnebago County Society and his invitation to members and officers to attend this meeting of the Council as a committee.

LEWIS had no report as President-Elect.

STONE attended the dedication of the plaque at Children's Memorial Hospital, commemorating activities of the Kiwanis Club and its program for research is spastic paralysis. Also attended recent meetings of the Tuberculosis Control Committee and the Committee on Medical History.

HOPKINS reported as Chairman of the Committee on Medical Service and Public Relations. Requested that Mr. Leary be sent to Michigan to attend their public relations meeting on February 1 in Detroit. Motion (Reichert-Montgomery) that Leary be authorized to attend this meeting. Motion carried.

LEARY tells of his recent activities in Public Relations, and as Secretary for the Committee on Post Graduate Education. Series of meetings planned for downstate societies to discuss public relations, see what they are doing, and what help they would like from the state society. Asks for Council advice and assistance along these lines.

NEAL told of legislative session, cheanges made in Springfield, probable changes in the operation of the Senate. Will have more to report as session advances. Discussion on proposed changes in coroner act, which has been under discussion in the Council, House of Delegates, by Bar Association and others.

Council was informed of two birthdays, E. H. Ochsner, to celebrate his 85th and Andy Hall, his 88th birthday. By proper action, Secretary instructed to send telegrams from the Council to these men extending congratulations and best wishes.

BLAIR gave report of the Educational Committee, referring to recent TV shows and reports from those viewing the presentations. Tells of distribution of "Health Talk" and sending speakers for talks before

lay groups. Difficulty in finding psychiatrists to make these talks. Tells of radio broadcasts under supervision of the Committee. Chicago office still having difficulty in procuring needed help. One former employee coming in to help out until another girl is found. Office would still like to have approval to purchase the audiograph. MOTION (White-Montgomery) that the committee be empowered to buy the audiograph for dictation and transcription. Discussion, Stone, Hamilton, Sweeney and Blair, who stated the total cost would be approximately $700.00. Hamilton stated that this outlay would not eliminate the need for another girl in the office. Van Dellen stated that the equipment should be available for the use of the Editorial Department. Generally agreed that this should be so stated. Motion carried.

Motion (Hellmuth-Vaughn) that the Chairman of the Council appoint a representative of the society to the joint emergency ambulance commission. Motion carried. Hellmuth stated that the Institute of Medicine is interested in this ambulance problem, and will have an editorial on the subject in the bulletin under date of January 15. This will likewise appear in the Illinois Medical Journal. REICHERT approved the idea, and stated that Hellmuth in his requests deserves the cooperation of the Society.

There was a general discussion, brought up by Reichert, relative to the advisability of sending the agenda to members of the Council prior to the meetings. Some matters might be more intelligently discussed if members the Councilors represent were asked their opinion on certain matters to come up. It was brought out that the agenda was usually made up and mimeographed two days before the meeting, and it would not be possible to set up the complete agenda a week before the meeting. It was finally agreed that for future meetings, the Secretary will include all matters in his report to the Council, which a week before the meeting are known to him.

VAUGHN told of his recent trip to Ireland, and several European countries, telling of medical schools in these countries and their opinions as to the practice of medicine as now conducted in those countries.

LIMARZI reported as Chairman of the Scientific Service Committee. Stated that bills had been received from county societies for certain speakers invited by the society directly without going through the Committee. The Committee will not pay for speakers under these conditions. Some speakers have written county societies offering to address them and the Committee does not approve these methods. Limarzi tells of a number of societies recently requesting service, and each of them has been properly cared for. ENGLISH stated that the Scientific Service Committee should be responsible for expenses of speakers sent by the committee, as has repeatedly been approved by the Council and it still stands.

HELLMUTH discussed the post graduate conferences as planned and referred to the State Medical Post Graduate Assembly which is now functioning. The Council on Medical Education of the A. M. A. has appointed a physician to work on a full time basis to aid this organization and set up its policies. The proposed plans discussed in much detail by a number of councilors. Hellmuth favors a careful and thorough fact finding study in the field of postgraduate work. Believes a survey such as was made a few years ago by the Academy of Pediatrics would bring good results. It was finally agreed that the committee should bring in its proposed plan when same was agreed upon and the Council would give it the proper consideration.

COLEMAN told of the meeting the preceding evening of the Medical Advisory Committee to the Illinois Public Aid Commission. Referred to reports given by VanDellen and Hess on vitamins and their indications. VanDellen in general and Hess in relation to children. Coleman told of recent complaints from participating physicians at the actions taken by the I. P. A. C. personnel. It was suggested that these reports of VanDellen and Hess be published in the Illinois Medical Journal as soon as possible.

SLAUGHTER discussed the problems of the Illinois Interprofessional Council. Told of the cordial reception given to a special committee from this Council by the new Governor of Illinois. The meetings of the Council have established better relationships among the participating professions. Mr. Neal and Mr. Leary have been of much service to the Council. Dr. Glenn Moore, representing the Illinois State Optometric Association on the Interprofessional Council addressed the Council, calling attention to another Optical Society which does conform to the ethical standards established in the present optometric act. It is stated that this group will endeavor to have the present act declared unconstitutional. More heartily approves the policies of the Interprofessional Council, and believes it will aid the several participating organizations and their membership as a whole.

WHITE told of the plans of the Kiwanis in setting up the research project at Childrens Memorial Hospital, and told of the placque which was placed in that institution the preceding day. Told of talks with members on the 1953 annual dues, and suggested that all members likewise discuss this with their societies and individual members who want additional information.

MONTGOMERY told of a problem in his area over actions taken in Evansville, Indiana, where they will not care for I. P. A. C. clients unless the usual rates for service are paid. A meeting has been arranged by hospital administrators in Evansville, which he and others will attend in the endeavor to work out a satisfactory solution. The president of the Indiana State Association will also be present. A report will be given by Montgomery at the next Council meeting.

TURNER told of a recent meeting of his committee on Tuberculosis Control held January 8. He referred to three amendments sponsored by the State Health Department which will be introduced in the Illinois Legislature, relative to Tuberculosis. These amendments were approved by his committee, and he hoped the Council will likewise approve them. Motion (Lewis-Hamilton) that this portion of Turner's report be approved. Motion carried. Turner told of another

proposed tuberculosis protection law which will be introduced, as sponsored by the Illinois State Tuberculosis Association, and which his committee approved.

STONE stated that this matter would be referred to the Committee on Medical Service and Public Relations. Turner's committee also studied an act prohibiting the employment in schools of persons having tuberculosis in a communicable form, and providing for periodic examination of school employees. Motion (O'Neill-Lundholm) that this portion of Turner's report be approved. Motion carried. The Committee also recommends that the Council authorize the appointment of a Committee on Tuberculosis Control in all county societies. Motion (White-Lewis) that Secretary so inform the county societies. Carried.

MULLER tells of plans of Committee on Arrangements for annual meeting, committees all appointed and told of their respective duties. Considering selecting an outstanding speaker for the annual dinner and mentions several names under discussion. The speaker this year will be scheduled first, after the dinner service, and the other part of the program will be presented later. Attention called by Muller to the C. M. S. Clinical Conference, March 3-6, 1953.

CROSS reported on the status of disease control by means of immunizing treatments. No case of smallpox in Illinois since 1947. Diphtheria close to the vanishing point, only 15 cases reported during 1952, and one death. Whooping cough with 11,759 cases in 1942, to only 719 in 1952. The Department of Public Health interested in preventing epidemics, while stimulating a demand for immunization to be carried out by the practicing physicians. Gave an interesting discussion of activities within the department and the periodic surveys that are being made. Is well pleased with the attitude of the physicians in Illinois toward the immunization programs. Discussion of the report by White, Vaughn and Reichert, who referred to the importance of booster shots.

NEWCOMB reports on a proposed amendment to the Workmen's Compensation Act, which would include persons with heart disease or other forms of disability and who suffer a subsequent injury or death. The present law keeps employers from employing a person with any previous impairment. There is a second injury provision in the present act, and the proposed amendment extends this provision to those who have a cardiac disability at the time of employment, in addition to other disabilities. By proper action the Council approves this amendment in principle, and referred it to the Committee on Medical Service and Public Relations.

Lundholm stated that everything in his district is quiet except in his home county. Their problem will be discussed later in the day. Believes that a lot of public relations work should be formulated at the county society level, and that the county societies should develop displays and exhibits for county fairs, using the same approach as has been developed for the state fair in Springfield.

SCATLIFF, as Chairman, Advisory Committee to the Womans Auxiliary, told of some plans made by the Auxiliary and some matters for which they desire Council advice. One of these, relative to membership in the Illinois Society for Medical Research. Asked for expression from Council on this subject. Motion (English-Hesseltine) that the Auxiliary be asked to accept the membership offered to them, and cooperate in every way possible with this group. Motion carried.

LUNDHOLM told of some problems in the Winnebago County Society relative to the current membership dues. The Society has the highest local dues of any component society in Illinois, and they have a committee present to get more information from the Council as to the reasons for the increase this year, as set by the House of Delegates. Doctor Rogers, as president of the Winnebago Society, told the Council of the objections in his Society, and asked a number of questions as to why the increase was made, what evidence to support the need for the increase, how will the membership dues be allocated, and what effect will that portion to go to the American Medical Education Foundation have, on the budget of the medical schools. Doctor Ford discussed the matter, stating he has personally been contributing to his own alma mater, and he is in favor of aiding the schools, but he wonders if this decision by the State Society is the proper method, and if it is entirely legal. Doctor Palmer, as Secretary, stated that members of his society are not in sympathy with this action, as they believe no one should tell them how their money should be spent. This is apparently the first time State Society funds have been allocated for any purpose other than that running the Society itself. Dr. Canfield said members of their Society thought before action was taken by the House of Delegates in 1952 on the annual dues, the matter should have been thoroughly discussed at the "grass roots" level, so that everyone would have known what was under contemplation before the meeting of the House of Delegates.

LUNDHOLM ended the discussion for the Winnebago Society committee, as their Councilor. Questions asked during this panel discussion, were answered by Sweeney, Camp, Stone, White and Hamilton. Hamilton told of the relatively few donors during 1952 from Illinois physicians to the A. M. E. F. to aid medical schools. It was brought out that quite a number of other State Medical Societies have for several years had much higher annual dues than Illinois; one large West Coast County Society assesses an initiation fee at the county level against their new members of $100.00. NEAL discussed the legality of the actions taken by the House and directed by the Council, showing that under the Constitution and By-Laws, the actions were entirely legal. It was shown that the matter of dues was left entirely to the House of Delegates, and the Council is responsible for allocating funds for the various functions of the Society. The Council has no authority to change the actions taken by the House relative to annual dues.

REICHERT referred to the fee schedule developed by the University of Illinois Division for Crippled Children, which was submitted by Dr. Herbert Kobes, and was mailed to members with the minutes of the

December meeting. The Division wants Council approval, and Reichert moved, second by Vaughn, that the Council approve the schedule as submitted, and the Secretary notify Dr. Kobes of the action. Motion carried.

HOELTGEN gave a progress report as Chairman of the Committee on Nursing. Told of several other training schools receiving temporary accreditation since his last report. A list of training schools already approved was reported, and mimeographed copies of the lists distributed to members. A meeting of the 14 State Conference will be held in Lincoln, Nebraska, this the second meeting of the group. Motion (Hamilton-Blair) that Hoeltgen be named as the official delegate from this Society to attend the conference. Motion carried.

ENGLISH gave a report as Chairman of the Committee on Branch Practice, telling of the hearing in Denver attended by representatives of the Springfield Clinic, Sangamon County Medical Society, and which he attended as Chairman of this committee. Told of the report of the Judicial Council, and actions by the House of Delegates on the report.

REISCH discussed the subject as pertaining to the Springfield Clinic, and referred to their brochure, a copy of which each member had received by mail. The Sangamon County Society will discuss the matter at an early meeting.

SECRETARY referred to a recent letter from Dr. Lull of the A. M. A., asking that local societies have someone to watch for statements unfavorable to medicine in editorials, speeches, etc., then endeavor to discuss the matter with the person responsible for the statements, endeavoring to give them truthful information. Secretary was instructed to notify all component societies.

HAMILTON discussed the "Magnuson Committee Report", telling of statements issued by Dr. Bauer, president of the A. M. A., and stated that in the near future the Board of Trustees would likewise have a report to be published in the Journal of the A. M. A. The entire report will be in five volumes, and volume 1 is now available.

MOTION (Sweeney-Fullerton) that the list of candidates for Emeritus and Past Service Retired memberships, as submitted by component societies, be approved. Motion carried.

MOTION (Reichert-Sweeney) that the bills as audited by the Finance Committee be approved and payment authorized. Motion carried.

By proper action the Council adjourned at 3:30 P. M., to meet again in regular session on March 8, 1953.

Harold M. Camp, M. D.
Secretary.

CORRECTION OF FUNNEL CHEST

The optimum age for correction of funnel chest is not altogether certain. The term, correction, is used to indicate that the complete or radical procedure is being considered. Lester, who has had an unusual experience in this regard, states that he has obtained his best results in children operated upon between 2 and 5 years of age. We believe this probably is the optimum period for surgery in those with confirmed funnel chest. After 2 years one can decide with reasonable certainty whether or not the lesion is progressive and, therefore, whether correction of the deformity is necessary. Those children operated upon before 5 years of age will not have developed irreversible changes in other structures as a result of the chest wall deformity. It has become increasingly clear that this does occur when marked deformities are allowed to go uncorrected until adulthood is reached. Even the cosmetic results are far from perfect under such circumstances. The sternocostal deformities may be almost completely corrected but skeletal and visceral changes associated with funnel chest persist, and often are of greater importance than the funnel chest itself. Skeletal changes, such as spinal curvature, are not corrected. Even the displacement and torsion of the heart frequently is only slightly improved. *I. A. Bigger, M.D., The Treatment of Pectus Excavatum or Funnel Chest. Am. Surgeon, Nov. 1952.*

NEWS OF THE STATE



BUREAU

Society News.—Worling R. Young, Geneseo, discussed maternal deaths in Illinois before the Bureau County Medical Society and the Woman's Auxiliary in Perry Memorial Hospital, Princeton, December 16.

CHAMPAIGN

Society News.—Major General Byron E. Gates, Chanute Air Force Base, addressed the Champaign County Medical Society, February 12, in Champaign, on "Problems of the Airman." P. A. Daly and O. T. Bonnett Jr. were inducted into membership in the society at this meeting.

COOK

New Branch Health Office.—On February 6 the first of twenty new branch offices was opened by the Chicago Department of Public Health at the Jane Addams housing project. The new unit is intended to care for 26,900 persons in an area bounded by Sixteenth Street, Ashland, Racine and Van Buren, according to the Chicago Daily News. The district health centers will make it unnecessary for persons to travel long distances for inoculations, prenatal, infant and maternal care, the report stated.

Special Program on School Health.—A joint meeting of the Chicago Pediatric and Chicago Medical Societies at Children's Memorial Hospital, February 17, was devoted to the theme "Clinical Evaluation of the School Health Program in the Chicago Public Schools." Speakers were: John L. Reichert, "The Health Program—Introduction"; Carl J. Marienfeld, "Cardiac Aspects of School Health"; John C. Bergmann, "Dental Aspects of School Health"; Richard E. Marcus, "Hearing Aspects of School Health"; Dephane A. Jensen, R. N., "School Health Councils", and Kenneth S. Nolan, "The School Health Program—Evaluation."

Personal.—Charles Huggins, professor of surgery, University of Chicago School of Medicine, was included in the ten recipients of the Modern Medicine Awards for Distinguished Achievement for 1953. Dr. Huggins was cited for his work on "furthering endocrine control of cancer and development of an operation for removing adrenal glands."

University News.—"My Year in India" was the title of an address during the University of Illinois College of Medicine Lecture Hour, January 7; the speaker was Carroll L. Birch, professor of medicine at the university. On February 11 the same hour was devoted to a talk by Arthur Kirschbaum, professor and head of the department of anatomy, University of Illinois College of Medicine, on "Experimental Production and Control of Cancer."

Prizes and Scholarships Awarded.—Howard G. Glassford, 2000 W. Van Buren St., Chicago, has received the Beaumont Memorial Prize for 1952 at the University of Illinois College of Medicine.

The Beaumont Prize, which carries a stipend of $200, is awarded to students of faculty members who have made important research contributions and have been recommended for consideration by heads of departments in the College of Medicine. Scholastic standing is considered in making the awards.

Beaumont Memorial Prizes were endowed by the late Dr. Frank Smithers of Chicago in memory of Dr. William Beaumont, famous surgeon and physiologist of the 19th century.

Yarros Scholarships have been awarded to four students in the College of Medicine. Stipends of $200 were received by Cedric M. Smith, 2031 DeKalb St., Chicago, and William R. Martin, 9047 S. Dante Ave., Chicago, both fourth-year students. Third-year students Milton Kramer, 3238 W. George St., Chicago, and Karl E. Jauch, 4106 N. Bell Ave., Chicago, have been awarded $100 each.

Needy and deserving students in the College of Medicine are eligible for the scholarships, which were established in honor of the late Dr. Rachelle S. Yarros by her husband, Mr. Victor S. Yarros of La Jolla, Cal. Prof. Yarros taught obstetrics and social hygiene at the College of Medicine prior to her retirement in 1938.

Lawrence D. Petz, 3000 N. Troy St., Chicago, has received the Ralph C. Berkelhamer scholarship awarded each year at the College of Medicine. Petz is a second-year student in the College of Medicine.

The scholarship, which consists of a $100 awards, was established three years ago by the Berkelhamer family of Chicago in honor of the late Dr. Ralph C. Berkelhamer.

Students who have completed at least one year in the College of Medicine are eligible for the scholarship. The Berkelhamer family stipulated that the scholarship may be awarded "to any needy and deserving student, with no prejudice as to race or religion."

Rea Scholarships have been won by three students in the College of Medicine. Recipients of the $100 prizes are Seymour L. Lustman, 2358 E. 70th Pl., Chicago, a third-year student; and Richard S. Webb, Jr., Allendale, Ill., and Ralph D. Ade, 2324 23rd St., Moline, Ill., second-year students.

The scholarships are awarded "to help pay the tuition fees of needy students." Scholastic standing, character, and financial need are considered in awarding the scholarships.

The annual income from a fund established in 1899 by the will of the late Dr. Robert Laughlin Rea is used for the scholarships.

Five students in the College of Medicine have been awarded Mooney Scholarships. Harold A. Shafter, 4056 N. Albany Ave., Chicago, and Charles G. Moertel, 119 N. 13th Ave., Melrose Park, Ill., both fourth-year students, have received $200 each. Stipends of $100 each were awarded to D. James Lowell, 5330 S. Harper Ave., Chicago, and Charles J. Koucky, 1517 Cortland St., Chicago, both third-year students; and H. Walter Beard, 166 Crest Rd., Glen Ellyn, Ill., a second-year student.

The Patrick and Bertha Mooney Memorial Fund provides $100 and $200 awards for assisting needy and worthy students attending the University of Illinois College of Medicine.

The funds are provided each year by Dr. F. P. Mooney of Philo, Ill., a graduate of the University of Illinois, as a memorial to his parents.

Branch Meetings.—The North Shore Branch of the Chicago Medical Society was addressed, February 3, by Richard V. Ebert, Clark professor of medicine, University of Minnesota Medical School, on "Physiology of Congestive Heart Failure." An earlier meeting of the Branch was addressed by Arthur J. Coombs, assistant clinical professor, University of Illinois College of Medicine, on "The Tonsil Problem", and Egbert H. Fell, clinical professor of surgery, at Illinois, on "Surgical Emergency of the Newborn and Infants."

The North Suburban Branch of the Chicago Medical Society was addressed at dinner January 12 by Walter S. Priest on "Aims and Objectives of the Chicago Heart Association"; Presenting the scientific program were John A. Bollinger, Evanston, on "Acute Small Bowel Obstruction" and Wolf W. Zuelzer, Detroit, on "Anemias of Early Life"; discussants were Mila Pierce and Louis Limarzi. Another meeting of the North Suburban Branch was addressed by Arthur H. MacKinnon, Evanston, on "Spontaneous Perforation of the Esophagus", and Alexander Brunschwig, on "Hypotensive Anesthesia."

Dr. Snapper Joins Chicago Faculty.—Dr. I. Snapper, noted Holland-born internist, who was formerly professor of medicine at the University of Amsterdam and chief of the department of medicine at Union Medical College in Peiping, China, has been appointed professor of medicine at the Chicago Medical School, according to a recent announcement by President John J. Sheinin.

After becoming a resident of the United States in 1944, Dr. Snapper was appointed director of medical education and physician to Mt. Sinai hospital, New York City, and during the war served as adviser to the office of the Surgeon General in Washington, D. C.

In addition to his post at the Chicago Medical School, Dr. Snapper continues as consulting physician to Mt. Sinai hospital in New York, and is director of medical education at Cook County hospital and professor of medicine in Cook County Graduate School of Medicine.

Society News.—At the February 20 meeting of the Illinois Chapter of the American College of Chest Physicians, members of the University of Chicago School of Medicine faculty presented the program: John F. Perkins, "Transpulmonary Oxygen Dissociation Curve as a Test of Pulmonary Function"; Donald Cassels, "Pulmonary Studies in Scoliosis"; William Barclay and Mr. William Manthei, "Report on Studies with Carbon 14 Labelled Isoniazid, and Robert H. Ebert, "Mediastinal Lesions".

Staff Election.—Dr. L. A. Holub has been named president of the medical staff of MacNeal Memorial Hospital, Berwyn; Dr. Ernest Hessl, vice president, and Dr. Mary B. Johnson, secretary.

JACKSON

New Regional Health Officer.—Dr. Samuel L. Andelman has recently been appointed health officer for the Southern Region of the Illinois Department of Public Health with headquarters at Carbondale. A native of Illinois, Dr. Andelman returns to this

state from Kentucky where he has served as health director of the Harlan County Health Department for more than six years. In his new position, Dr. Andelman will serve the entire southern region which includes the counties of Clay, Edwards, Franklin, Hamilton, Jefferson, Marion, Monroe, Perry, Randolph, Richland, Union, Washington, Wayne and Williamson.

KNOX

Society Election.—New officers of the Knox County Medical Society were Merrill C. Beecher, Knoxville, president; Charles B. Paisley, Galesburg, vice president, and Richard J. Graff, Galesburg, secretary-treasurer. J. C. Redington, Galesburg, was named delegate to the Illinois State Medical Society; Alexander M. Duff Jr., Galesburg, alternate delegate, and F. M. Huff, Galesburg, censor. Harold E. Himwich, Galesburg, Delbert G. H. Nelson, Abingdon, and J. F. Erffmeyer, Galesburg, have been elected to membership in the society. Karl H. Pfuetze, Chicago, addressed the society, January 15, on "Treatment of Tuberculosis with Chemotherapeutic and Antibiotic Agents."

LAKE

Society News.—The Lake County Medical Society was addressed at the Lake County Tuberculosis Sanatorium, Waukegan, February 10, by Oscar Gaarder of Professional Services, Madison, Wis., on "Take Home Pay for the Doctor."

LA SALLE

Fifty-Two Years Secretary.—Dr. George A. Discus, Streator, who began practicing medicine in 1891, recently completed his fifty-second year as secretary of the North Central Illinois Medical Association.

LIVINGSTON

The doctors of the Livingston County Medical Society entertained their wives Thursday evening, February 12, at the Honegger House Cafe, Fairbury.

The speaker of the evening was Doctor William Bethard, whose topic was "The Atom and Medicine."

Doctor Bethard is a professor at the University of Chicago where he has been working with the Atomic Energy Commission at the Argonne Hospital.

Doctor Bethard is a grandson of the late William J. Bethard and a son of Fred D. Bethard, deceased, both prominent former residents of Fairbury. His mother is now living in San Diego, California.

MACON

Personal.—Two Decatur physicians, Drs. Phillip Lynch and Louis Walker have been recalled to the Navy. Dr. Lynch has reported to Naval Ordnance Test Station, China Lake, and Dr. Walker to the U.S.S. Tidewater, a destroyer tender at Norfolk, Va.

PEORIA

Health Officer Extends Activities.—Dr. Fred Long, health officer for the Peoria City Health Department, has been appointed health officer for the Peoria County Health Department, succeeding Dr. H. R. Marlatt who resigned to join the staff of the Peoria State Hospital. Dr. Long will direct both city and county health offices.

ROCK ISLAND

Society News.—Dr. J. L. Ehrenhaft, department of surgery, University Hospital, Iowa City, discussed "Surgical Treatment of Chest Conditions" before the Rock Island County Medical Society at a meeting in the Lutheran Hospital Nurses' Home, February 10.

SANGAMON

Staff Election.—At the annual business meeting of the attending staff of Memorial Hospital, Springfield, January 6, the following officers were elected: Robert J. Patton, president; A. E. Steer, vice president; J. Keller Mack, secretary; R. S. Campbell, Frank M. Davis, and H. B. Henkel Sr., all members of the executive committee.

Society News.—Edward H. Reinhard, department of internal medicine, Washington University School of Medicine, St. Louis, addressed the Sangamon County Medical Society February 5 at the Springfield Theatre Guild, on "Laboratory Diagnosis and Treatment of Disorders of the Spleen."

VERMILION

Interprofessional Meeting.—A joint meeting of the medical and dental societies with the bar association of Vermilion County was held at the Hotel Wolford, Danville, February 3. The speaker was Mr. Erwin W. Roemer on "Medical Testimony in Personal Injury Cases." Dr. William Lees, Chicago, addressed the January 6 meeting of the society on "Early Diagnosis of Chest Lesions Especially Cancer of the Lung."

GENERAL

Camp for Diabetic Children.—A summer camp for diabetic children will be opened for the fifth season under the auspices of The Chicago Diabetes Association, Inc. from July 21, 1953 to August 10, 1953 at Holiday Home, Lake Geneva, Wis. In addition to the regular personnel of the camp, there will be a staff of dieticians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association. Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $150.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

Service Unit, Chicago Diabetes Association
110 South Dearborn Street
Chicago 3, Illinois.

Limited capacity requires prompt application.

Conference on Physicians and Schools.—Arrangements for the Fourth National Conference on Physicians and Schools, popularly known as the Highland Park Conference, to be held September 30 through

October 2 at Moraine-on-the-Lake Hotel, Highland Park, Illinois, have been announced by Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association. These conferences have been sponsored biennially by the Bureau since 1947.

Invitations to send official delegates to the Conference will be mailed to all state medical associations, state departments of health and state departments of education in the near future. Representatives of national health agencies concerned with children of school age and consultants to former Highland Park Conferences will also be invited.

Detailed arrangements for the Conference have not yet been completed, but to provide more time for discussion and exchange of experiences with colleagues from other states, the Conference will extend over three days rather than two. Opportunity for discussion of a greater number of specific subjects is being arranged. The Conference will close with the traditional banquet on the evening of the final day.

Specific information will accompany the formal invitation, but all state medical associations and health and education departments are requested to note the date of the Fourth National Conference on Physicians and Schools and make plans to be represented.

Maternal and Infant Mortality Rates Set New Record.—The year 1952 was a record one for babies in Illinois with the number of births reaching an all-time high and the infant death rate falling to a new low.

Provisional tabulations which were reported to Governor William G. Stratton by Dr. Roland R. Cross, director of the State Department of Public Health, showed that births last year exceeded the 1951 record total by 3,902. The new record is 201,827 as compared to 197,925 in 1951.

During last year 5,034 babies died before reaching their first birthdays. This was an all-time low infant death rate of 24.9 infant deaths per one thousand live births. Previous low was 25.2 in 1951. The infant death rate has dropped each year since 1940.

Dr. Cross' report also showed that another record mark, low death rate among all ages, was equalled in 1952. A total of 92,703 deaths was recorded. Some were among out-of-state residents but since, similarly, not all Illinois residents die in Illinois it was estimated that the total deaths of residents of this state will be 92,600 when information for 1952 is complete. This would equal last year's record low death rate of 10.5 deaths per one thousand inhabitants.

Postgraduate Conference.—A Postgraduate Conference was arranged by the Postgraduate Education Committee of the Illinois State Medical Society in cooperation with the staff of Wesley Memorial Hospital, Chicago, January 28 at St. Mary's Hospital and the Cairo Hotel, Cairo. With Willard W. Fullerton, M.D., Sparta, Councilor for the Tenth District, presiding, the following program was presented.

Panel: Cardiac Surgery.

Walter S. Priest, M.D., Chairman, Associate Professor of Medicine, The Medical School, Northwestern University.

"Medical Aspects", Dr. Priest.

"Physiological Aspects", Gerald R. Graham, M.D., Assistant Professor of Medicine, The Medical School of Northwestern University.

"Surgical Aspects", Edward E. Avery, M.D., Chicago.

Panel: The Management of Surgical Patients.

Walter O. Maddock, M.D., Chairman, Elcock Professor of Surgery, The Medical School of Northwestern University.

"Water and Electrolyte Balance", Dr. Maddock.

"Pre- and Post-Operative Care", Peter A. Rosi, M.D., Associate Professor of Surgery, The Medical School of Northwestern University.

"Indications for the Use of Blood Tranfusions", Earl O. Latimer, M.D., Assistant Professor of Surgery, The Medical School of Northwestern University.

Intermission

Symposium: The Management of Arthritis.

"Medical Aspects", David E. Markson, M.D., Associate Professor of Medicine, The Medical School of Northwestern University.

"Surgical Aspects", Hampar Kelikian, M.D., Assistant Professor of Bone and Joint Surgery, The Medical School of Northwestern University.

"Do Ovarian Tumors Cause Uterine Bleeding?" Melvyn A. Bayly, M.D., Clinical Assistant in Obstetrics and Gynecology, The Medical School of Northwestern University.

"Office Endocrinology", Emery G. Grimm, M.D., Associate in Medicine, The Medical School of Northwestern University.

"Immunization in Children", Edmond R. Hess, M.D., Clinical Assistant in Pediatrics, The Medical School of Northwestern University.

The scientific program was followed by an inspection tour of the new building of St. Mary's Hospital, and a fellowship hour in the assembly room of its nurses' home, as guests of the Alexander and Pulaski County Medical Societies.

Wives of those attending the meeting were cordially invited to be entertained through the afternoon in the Manor Home, Cairo, and to attend the fellowship hour and the evening session.

In the evening Charles Yarbrough, M.D., Cairo, President, Alexander County Medical Society presided. Speakers were Harold M. Camp, M.D., Monmouth, Secretary, Illinois State Medical Society, on "Medical Organization and Its Work," and Vincent J. O'Conor, M.D., Professor of Urology, The Medical School of Northwestern University, on "Urinary Antiseptics: Past and Present, Fact and Fancy."

"How's Your Health" over WGN-TV.—*How's Your Health",* produced by the Educational Committee

of the Illinois State Medical Society in association with WGN-TV, has presented the following telecasts:

Ormand C. Julian, clinical assistant professor of Surgery, University of Illinois College of Medicine, January 7, on "Entering the Heart Valves." Equipment was provided by the Cambridge Instrument Company.

David Cohen, professor of dermatology, Chicago Medical School, January 14, on "Ringworm of the Scalp."

Charles D. Krause, assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, January 21, on "So You're Expecting a Baby."

Leo Kaplan, associate professor of neurology and psychiatry, Stritch School of Medicine of Loyola University, January 28, on "What Is Neurology?"

Richard A. Perritt, senior attending ophthalmologist, Wesley Memorial Hospital, February 4, on "Is It a Cataract?" Equipment was provided by Uhlemann Optical Company, Mager Gugelmann, and Bausch-Lomb Optical Company.

Hugh A. Flack, instructor in medicine, Northwestern University Medical School, February 11, on "Recording Your Heart Beat." Equipment was provided by Cambridge Instrument Company.

Charles N. Pease, attending orthopedic surgeon, Children Memorial Hospital, February 18, on "Your Child's Bones."

Theodore R. Van Dellen, assistant dean at Northwestern University Medical School, and Medical Editor of the Chicago Tribune, appeared in all telecasts as moderator.

"Your Doctor Speaks" over FM Station WFJL.— In the radio series *"Your Doctor Speaks"* over *FM Station WFJL,* the following physicians appeared in transcribed broadcasts under the auspices of the Educational Committee of the Illinois State Medical Society:

Leonard Weinstein, department of orthopedic surgery, Michael Reese Hospital, January 8, "Be Kind to Your Feet."

Samuel H. Fraerman, member of the orthopedic staff, Michael Reese Hospital, January 15, "Will They Grow Out of It."

Harry Benaron, medical director, Chicago Maternity Center, January 22, on "Prenatal Care."

Gail R. Soper, member of the staff of Evanston Hospital, January 29, on "Misunderstood Facts About Your Eyes."

Frank E. Doyle, member of the staff, St. Anne's Hospital, Oak Park, February 5, on "Care of the Aged."

Patrick H. McNulty, chairman, department of urology, Little Company of Mary Hospital, February 19, on "Hematuria."

Sanford A. Franzblau, instructor in medicine, University of Illinois College of Medicine, February 26, on "Air Travel for the Doctor's Patient."

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Leonidas Berry, Blue Island Woman's Club, January 13, on "What Chicago is Doing for Narcotic Addiction Among Adolescents."



"How's Your Health" produced by the Educational Committee of the Illinois State Medical Society in association with WGN-TV. So realistic was the effect of this program on "Emergency Surgery" December 10, 1952 that even professional persons believed the telecast to be coming from a hospital. Elaborate equipment to simulate a real operating room was provided by V. Mueller and Company, Ohio Chemical Company, Abbott Laboratories and Illinois Masonic Hospital.

Arthur W. Fleming, Chicago, Child Study Department, Harvey Evening Woman's Club, at 8 p.m., January 29, on "Problems of Parenthood."

Charles I. Fisher, Salvation Army Catherine Booth Hospital and Clinics, February 11, on "Superstitions About Health."

George M. Cummins, Northwest Lions Club, February 3, and Gold Coast Lions Club, February 11, on "Medical Aspects of Aging."

E. Bradley Sylvester, Joliet, Junior Woman's Club of Kankakee, February 4, on "Superstitions About Health."

Alfred Flarsheim, Toman Library Forum, Chicago, February 20, "Psychiatric Problems in Vocational Adjustment."

Arthur Rosenblum, PTA Red Letter Health Day, District number 1, February 25, "Sleep and Nutrition."

Lawrence Breslow, PTA Red Letter Health Day, District number 24, February 26, on "Sleep and Nutrition."

Arthur Fleming, PTA Red Letter Health Day meeting, District number 25, February 27, on "Sleep and Nutrition."

Joseph Christian, Oak Park, PTA Red Letter Health Day meeting District number 25, February 27, on "Rheumatic Fever and Other Childhood Heart Conditions."

Louise Tavs, Chicago, Pekin Woman's Club, March 6, in Pekin, "A Cosmetic is a Chemical."

Earle E. Wilson, Kiwanis International in Chicago, March 10, on "Personality is Everybody's Business."

Frank E. Doyle, Oak Park, Industrial Editors Association, March 11, on "The Family Doctor Looks at the Industrial Editor."

Joseph Christian, Oak Park, West Chicago Mothers' Club, March 18, in West Chicago, on "Psychology of the Preschool Child" with special reference to behavior problems.

Earle E. Wilson, Oak Park, Elmwood Park Women's Club, March 19, on "Growing Old Gracefully."

Margaret M. Kunde, Windsor Park Woman's Club, March 31, on "Superstitions about Health."

Ann Fox, Woman's Auxiliary, Vermilion County Medical Society in Danville, April 7, "There's No Business Like Medical Business."

Thomas H. Mercer, Oak Park, Madison School PTA, in Hinsdale, April 15, on "Sex Education for Children."

Franklin R. Fitch, Sumner School PTA, April 15, on "Social Hygiene is a Family Affair."

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Karl F. Pfuetze, Chicago, Knox County Medical Society in Galesburg, January 15, on "Treatment of Tuberculosis with Chemotherapeutic and Antibiotic Agents."

Irwin Dritz, Chicago, La Salle County Medical Society in La Salle, January 8, on "The Patient as an Anesthesia Risk."

Gilbert H. Marquardt, Chicago, Kankakee County Medical Society, January 20, on "Medical Problems in Geriatrics."

John L. Keeley, Chicago, Kane County Medical Society in Elgin, February 11, on "Surgical Emergencies in Infants and Children."

Marc H. Hollender, Chicago, La Salle County Medical Society in La Salle, February 12, on "Psychological Aspects of the General Practitioner's Treatment of the Cancer Patient."

William A. Larmon, Chicago, Logan County Medical Society in Lincoln, February 19, on "Low Back Pain."

Matthew J. Brunner, Chicago Heights, Kankakee County Medical Society in Kankakee, February 17, on "Dermatologi Diseases of Allergic Nature."

Edwin N. Irons, Chicago, Marion County Medical Society in Centralia, February 19, on "Antibiotics."

Ralph Spaeth, Chicago, Rock Island County Chapter, Illinois Academy of General Practitioners in Moline, February 24, on "Infectious Diseases."

Robert M. O'Brien, St. Louis, Montgomery-Macoupin County Medical Societies, in Litchfield, February 24, on "Foot Diseases of Interest to the General Practitioner."

Alex J. Arieff, Chicago, McLean County Medical Society in Bloomington, March 10, on "What is Psychosomatic Medicine?"

Ernest D. Bloomenthal, Chicago, Henry-Stark County Medical Societies, March 11, on "Hemorrhoidectomy."

Fred H. Decker, Peoria, La Salle County Medical Society in Streator, March 12, on "X-Ray Diagnosis: Problems and Errors."

Carl J. Marienfeld, Chicago, Kankakee County Medical Society in Kankakee, March 17, on "Rheumatic Fever in Children."

Harry F. Dowling, Chicago, Iowa-Illinois Central District Medical Association in Rock Island, March 18, on "Antibiotics."

James B. Waller, Decatur, Logan County Medical Society in Lincoln, March 19, on "Obstetrical Emergencies."

James J. Callahan, Chicago, Lee-Whiteside County Medical Societies, near Rock Falls, March 19, on "Fractures of the Extremities and Their Treatment."

L. Martin Hardy, Chicago, DeKalb County Medical Society in DeKalb, March 24, on "Differential Diagnosis of Abdominal Pain in Children."

John Soukup, Chicago, La Salle County Medical Society in Ottawa, April 9, on "Treatment of Placenta Praevia."

Louis R. Limarzi, Stock Yards Branch to Chicago Medical Society, April 16, on "Diagnosis and Treatment of Anemia."

Harvey S. Allen, Chicago, Logan County Medical Society in Lincoln, April 16, on "Treatment of Burns."

DEATHS

Clark A. Buswell, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1900, died February 9, aged 82. He had practiced medicine on Chicago's north side for 50 years.

Edgar C. Cook, retired, Mendota, who graduated at Harvard Medical School in 1917, died February 6, aged 63, in the Mendota Community Hospital.

Harold Earnhart, Wilmette, who graduated at the University of Oklahoma School of Medicine in 1929, died February 7, aged 49. He was an industrial physician in the research department of Swift and Co.

William E. Fritschle, Olney, who graduated at the University of Louisville (Ky.) Medical Department in 1893, died in St. John's Hospital, Springfield, November 21, aged 83, of carcinoma of the bladder and coronary embolism.

Dr. Leonard Gaynes, Chicago, who graduated at Loyola University School of Medicine in 1925, died January 29, aged 53. He had served as a major in the Army Medical Corps in World War II.

Dr. James E. Goodman, Pleasant Hill, who graduated at Barnes Medical College, St. Louis, in 1911, died recently, aged 69.

Dr. Samuel S. Harriman, Lyndon, who graduated at Kentucky School of Medicine, Louisville, in 1892, died November 13, aged 89.

Arthur H. R. Krueger, Chicago, who graduated at the College of Physicians of Chicago, School of Medicine of the University of Illinois in 1906, died January 31, aged 70.

Walter John Kutas, Chicago, who graduated at the Chicago Medical School in 1932, died in Columbus Hospital, November 30, aged 48.

Werner Lonsen, Chicago, who graduated at Friedrich-Wilhelms-Universitat Medizinische Fakultat, Berlin, in 1917, died February 8, aged 61, in Sherman Hospital, Elgin. He was a member of the staffs of Elgin State, Michael Reese and American Hospitals.

Sarah Conley O'Connell, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died February 4, aged 89. She was formerly medical examiner for the Catholic Order of Foresters.

Clarence Ohlendorf, Park Ridge, who graduated

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at Northwestern University Medical School in 1918, died October 20, aged 65 of cerebral hemorrhage.

Herbert E. Parsons, retired, Decatur, who graduated at the University of Illinois College of Medicine in 1917, died October 22, aged 68, in Crane, Mo., where he was visiting a brother.

Andrew Athanasios Petrakos, Chicago, who graduated at National University of Athens School of Medicine, Greece, in 1923, died November 28, aged 54, of carcinoma of the rectum.

Robert H. Saunders, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died December 23, aged 71. He was a member of the staff of Illinois Masonic Hospital.

Walter R. Schussler, retired, Orland Park, who graduated at Bennett Medical College in 1889, died January 17, aged 84.

Jesse S. Trice, Chicago, who graduated at Jenner Medical College, Chicago, in 1917, died February 11, aged 69, while visiting in Savannah, Ga. He had been with the Chicago Board of Health for 34 years.

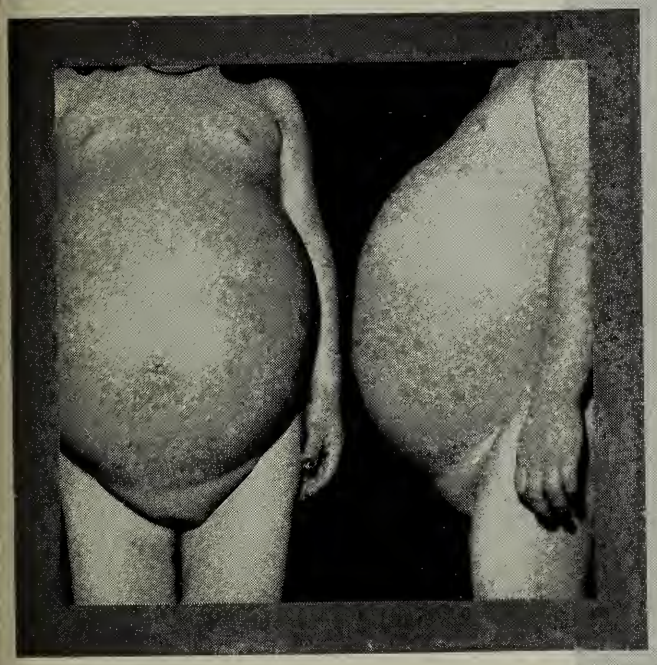
OBESITY

The people who are overweight are those who consistently, over long periods of time, take in more food than they utilize. The usual reason they do this is simply that they enjoy eating. Not only do they get satisfaction out of a good meal but also, when things are going badly for them, when they are under pressure or tension, they eat more because it makes them feel better. This group of people nearly all recognize the pleasure which they get out of eating and the difficulty which they have in controlling their appetites. Since most of them are otherwise organically normal, the problem is that of helping them control their appetites. In this sense psychotherapy belongs in the hands of the family doctor. One of the things that the doctor can do is to give these people support and encouragement in a field in which they are notoriously weak-willed. In addition to giving them a diet, he can interest them in various forms of group reduction classes, charm classes, or dietary groups. These converge the patient's activities and interests into a group which gives him the support of other people with a similar problem. This procedure is used a great deal by commercial reducing establishments. These so-called salons enroll their clients in groups and work to develop a group spirit and morale. I would guess that their methods are more effective than our own attempts to do the same thing on an individual basis with each patient. Likewise, the doctor may prescribe some medication, such as amphetamine, ostensibly for the purpose of reducing appetite, although the degree to which these medications reduce appetite seems to be pharmacologically small but psychologically large. The important point is to recognize that the prescription of a pill to reduce appetite is a reasonable form of psychologic support, so long as the doctor does not prescribe some medicine which does more harm than good. *Treatment of Obesity. Am. J. Med. Oct. 1952.*

moderation for variation..

in the blended diuretic regimen

In the long-term regimen, Calpurate meets the clinical need for moderate diuretic action, sustained effectiveness, and minimal toxicity. Calpurate also promotes increased cardiac output.



Calpurate is the chemical compound, theobromine calcium gluconate... unusually free from gastrointestinal and other side effects... does not contain the sodium ion.

to 'lighten the load' in congestive heart failure

Calpurate is particularly indicated:

when edema is mild and renal function adequate...

during rest periods from digitalis and mercurials...

where mercury is contraindicated or sensitivity to its oral use is present...

for moderate, long-lasting diuresis in chronic cases.

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the moderate, non-toxic diuretic

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SUPPLIED: Calpurate Tablets of 500 mg. (7½ gr.)
Calpurate Powder
Calpurate with Phenobarbital Tablets—
16 mg. (¼ gr.) phenobarbital per tablet

PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



THE BENEFIT OF RESPIRATORY EXERCISES IN THE EMPHYSEMATOUS PATIENT

Warde B. Allan, M.D. In THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES, 224:3:320, September 1952.

In summarizing briefly the mechanics and physiology of emphysema, it is apparent that the lung volume is greatly increased, the residual air greatly increased, the ventilatory exchange greatly reduced, and the vital capacity is usually reduced. The maximum breathing capacity is always considerably below the estimated normal. As the early stages of emphysema are not recognizable, it is almost impossible to prevent or to retard its gradual and sometimes rapid development, and in the treatment of the established state most measures have been without effect.

After observing many cases of emphysema, Allan felt that exercises might be employed, stressing upper abdominal and lower thoracic breathing thus bringing the diaphragm into a more active role during respiration. In the past three and a half years he has taught special respiratory exercises to more than 235 patients who have emphysema. Most of these patients have had an associated bronchitis, and most of them were in the older age group. The results have been very good.

It is of paramount importance to impress upon the patient being taught such exercises that his breathing mechanism can be helped. It is then demonstrated to the patient that instead of struggling to make the thorax move, it is much better and simpler to use the abdominal muscles. Then it is shown that the expiratory phase of respiration is the important feature, and instead of being passive he is able to make it active, with the result that the inspiratory phase becomes passive rather than active. These patients can rapidly accommodate their respirations to conform with this newer concept.

It is explained to the patient that this treatment is useful in chronic chest diseases in which there has developed constant outflow obstruction. This also applies to asthma of long duration which has resulted in obstructive emphysema more severe than the paroxysmal episodes of asthma. The purpose of the treatment is to re-educate the respiratory pattern to an involuntary continuous function in which emphasis is placed on expiration as the active phase and inspiration as the passive phase. It is emphasized that there is no set of exercises which can be mimeographed and handed to patients to be done at home. The importance of individual differences and the day to day developments cannot be overemphasized nor can they be anticipated. Therefore, each patient is a different problem and the specific prescriptions are made every day according to progress made and stumbling blocks which develop.

A series of exercises devised for Allan by a

(*Continued on page* 48)



entral nervous "pacifier"...

Mephate®

Robins

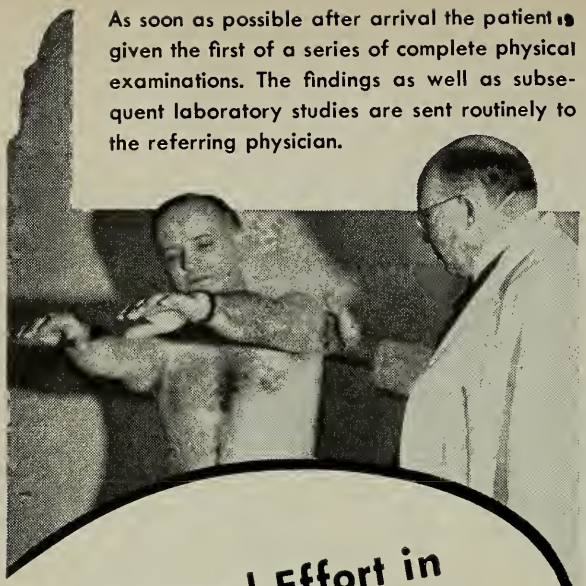
In Mephate 'Robins', the clinical usefulness of mephenesin per os has been significantly heightened by the inclusion of glutamic acid hydrochloride, which improves absorption and enhances effectiveness for many patients otherwise unresponsive.* Provides a relaxant effect on skeletal muscle spasm; an ameliorating effect on tremor; and a relief of anxiety without dimming consciousness. Particularly helpful in abnormal neuro-muscular conditions such as rheumatic disorders, disc syndromes and cerebral palsy; alcoholism, anxiety tension states and psychiatric states.

In each Mephate Capsule, 0.25 Gm. mephenesin — with 0.30 Gm. glutamic acid hydrochloride. Adult dosage starts at 2 capsules 3 or 4 times a day, preferably with food or liquids.

*Hermann, I. F., and Smith, R. T.: JL.-Lancet 71:271 (July), 1951.

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Ethical Pharmaceuticals of Merit since 1878



As soon as possible after arrival the patient is given the first of a series of complete physical examinations. The findings as well as subsequent laboratory studies are sent routinely to the referring physician.

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TREATING the
ALCOHOLIC
PATIENT

The system of therapy at The Keeley Institute is aimed (1) at overcoming the *acute attack* of alcoholism; restoring the patient's well-being, and (2) through group and individual re-education attaining a condition of *permanent sobriety*.

At all times the regimen of treatment is well coordinated under the direction of a staff of experienced full-time physicians who are members of the American Medical Association.

When you refer a patient to The Keeley Institute, you know that he will be taken care of as your patient and you are continually informed of his progress.

Member, American Hospital Association
Member, Illinois Hospital Association
The Keeley Institute is accredited by the Council on Medical Education and Hospitals of the A.M.A.

Complete information, including rates, will be furnished to physicians on request.

THE KEELEY INSTITUTE
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Physical Medicine (Continued)

qualified physical therapist are included in this article. They have been found to be a very useful adjunct in the treatment of emphysema.

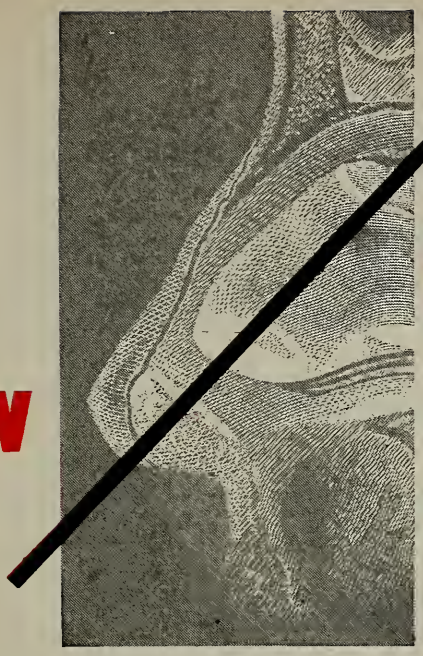
ABSENCE OF CLINICAL EVIDENCE OF DESTRUCTIVE LESIONS OF SYMPATHETIC NERVOUS SYSTEM IN ACUTE ANTERIOR POLIOMYELITIS

Lewis J. Pollock, M.D., Norman B. Dobin, M.D., Benjamin Boshes, M.D., Alex J. Arieff, M.D., Herman Chor, M.D., I. Finkelman, M.D., Meyer Brown, M.D., Irving C. Sherman, M.D., Erich Liebert, M.D., and Eli L. Tigey, M.D., Chicago. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 67:6: 725, June 1952.

There is need for clarification of the reports upon disturbances in functions of the sympathetic nervous system in acute anterior poliomyelitis. Often coupled with reference to the work of others, and with reports of authors themselves upon pathologic changes in the intermediolateral column of cells and in the ganglia of the sympathetic chain, is a description of some change in function of the sympathetic nervous system, leading to the assumption that the dysfunction noted is related to the pathologic changes described. For the most part, evidence of such dysfunction has consisted of some one sign or symptom, such as excessive sweating, increased electrical skin resistance in the axillae, or temporary retention of urine during the acute stage.

Ninety-one patients suffering from acute anterior poliomyelitis during the fall of 1950 were examined at the Chicago Municipal Contagious Disease Hospital. The studies conducted on these patients consisted of measurement of the skin temperature, electrical skin resistance, and sweating; determination of the relative humidity of the skin by a hygrometer; oscillometry, and cold-pressor tests. In the study of skin temperatures, a significant increase in skin temperature, differences between paralyzed and unparalyzed extremities, and a skin-temperature gradient were sought. In the study of amplitude of vascular oscillations, the ratio of the amplitude of the oscillations in the leg and that of oscillations in the forearm was estimated; similarly, the ratio for paralyzed and unparalyzed extremities was determined. In respect to electrical skin resistance and sweating, the measurements on the

(*Continued on page* 50)



new Gantrisin Nasal Therapy

Wider antibacterial spectrum Gantrisin Nasal Solution provides a wider antibacterial range for the local treatment of sinusitis and other upper respiratory infections, including sequelae of the common cold.

Well-tolerated vasoconstrictor Gantrisin Nasal Solution also contains phenylephrine hydrochloride which is "relatively nontoxic; applied to mucous membranes, it reduces swelling and congestion" (N.N.R., 1952, p. 190.)

Easy on the patient Gantrisin Nasal Solution gives patients soothing decongestion for hours at a time . . . promotes drainage.

Stable Gantrisin Nasal Solution is stable at room temperature so there is no need for refrigeration.

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DOSAGE: One to four times daily by dropper or atomizer into the nostrils, by Proetz displacement technique, nasal packs or instillation following antral puncture.

CAUTION: All shrinking agents eventually cause nasal congestion if overused. Should undesirable reactions occur in patients sensitive to sulfonamides, discontinue use immediately

PACKAGES: 1-oz and 16-oz bottles. Gantrisin Nasal Solution contains 4% Gantrisin in the form of the diethanolamine salt, 0.25% phenylephrine hydrochloride and phenylmercuric nitrate, 1:100,000. Chemically, Gantrisin is 3,4-dimethyl-5-sulfanilamido-isoxazole.

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paralyzed side were compared with those on the unparalyzed side. Finally, when any one of these methods served to indicate a dysfunction, effort was made to determine whether such a conclusion could be confirmed by the other methods of examination.

In summary, it may be said that a single indication of possible dysfunction occurred in significant numbers and was more frequently found in unparalyzed extremities. A combination of two indications was found in too few cases, and with only slightly greater frequency in paralyzed extremities, to be significant. In a very few cases a combination of three indications was found about equally in paralyzed and in unparalyzed extremities. In no case was there found a combination of all four indications of possible dysfunction of the sympathetic nervous system.

THE CHRONIC PULMONARY INVALID AFTER POLIOMYELITIS

James J. Waring, M.D., M.A.C.P. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:4: 252, August 1952.

Death of the poliomyelitis patient usually is due to respiratory failure, which may result from failure of the pump, from obstruction of airway, from pulmonary edema, from atelectasis, or aspiration pneumonitis.

It is very easy for the pulmonary invalid from poliomyelitis to slip back into complacent, resigned, or despairing helplessness. As long as he resents this helplessness and is determined to rehabilitate himself, further improvement is not only possible, it is certain. The patient's attendants (nurse, family, physician) must not permit the patient to relax his efforts. Skilled and equally determined physical therapy supplies the most important stimulation to his determination.

A vital part of the program and a part perhaps too often neglected or not appreciated for the patient with both limb and respiratory disability is the effort to improve the damaged ventilatory machinery. Weakened respiratory muscles can be strengthened; diaphragmatic action can be improved surprisingly with properly designed exercise. The patient must prac-

(*Continued on page 52*)

ACCIDENT
HOSPITAL
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INSURANCE

For Physicians, Surgeons, Dentists Exclusively



$5,000 accidental death **Quarterly $8.00**
$25 weekly indemnity, accident and sickness

$10,000 accidental death **Quarterly $16.00**
$50 weekly indemnity, accident and sickness

$15,000 accidental death **Quarterly $24.00**
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COST HAS NEVER EXCEEDED AMOUNTS SHOWN

ALSO HOSPITAL INSURANCE

	Single	Double	Triple	Quadruple
60 days in Hospital	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
Child to age 19	1.50	3.00	4.50	6.00
Child over age 19	2.50	5.00	7.50	10.00

$4,000,000.00 INVESTED ASSETS

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

$18,900,000.00 PAID FOR CLAIMS

50 years under the same management

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$200,000.00 deposited with State of Nebraska for protection of our members

in asthma  **edema of congestive heart failure**  **paroxysmal cardiac dyspnea** 

GLYTHEONATE®

[Theophylline-Sodium Glycinate Patch]

a xanthine that is *fully effective orally* because it is *well tolerated orally*

GLYTHEONATE PATCH

GLYTHEONATE
tablets and syrup

Each tablet, or teaspoonful (5 cc.) of syrup, contains: Theophylline-Sodium Glycinate 325 mg. (5 gr.), representing Theophylline U.S.P. 162 mg. (2½ gr.).

Bottles of 100 and 500 tablets. Syrup in pint and gallon bottles.

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GLYTHEONATE
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Phenobarbital 16.2 mg. (¼ gr.)

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Racephedrine Hydrochloride 24.3 mg. (⅜ gr.) and Phenobarbital 16.2 mg. (¼ gr.)

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Rutin 20 mg., and Phenobarbital 16.2 mg. (¼ gr.)

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Rectal dosage for emergency use. Each contains: Theophylline-Sodium Glycinate 0.78 Gm. (12 gr.), representing Theophylline U.S.P. 0.39 Gm. (6 gr.). Boxes of 12.

THE E. L. PATCH CO. — STONEHAM, MASSACHUSETTS

tice coughing to help the recovery of this vital function.

The thorax must not be allowed to become "frozen." Positive pressure inflation of the lungs several times daily will help to keep the thorax flexible. This is very important, especially if the patient has learned "frog-breathing" or glosso-pharyngeal breathing. If the thorax still remains flexible, the patient can by voluntary effort ventilate his lungs easily by this method. If the chest has become "frozen," "frog-breathing" will be markedly restricted.

This extraordinary method of breathing, dependent upon voluntary effort and, therefore, not usable during sleep, has been learned accidentally by some patients. It has been described by Bail in California. The patients pump air into the lungs by action of tongue, mouth, cheeks, pharynx, and larynx. Strangely enough air flows down through the larynx into the lungs and little if at all into the stomach. With each gulp of "pumping" of air the glottis opens and closes again to hold the air in the chest. After the lungs have been filled to capacity, the patient voluntarily releases the glottis and by thoracic and pulmonary elasticity the lungs are emptied.

Frog-breathing not only gives adequate oxygenation, but it enables the patient to talk more loudly. Perhaps because of the sudden release of expiratory pressure, it assists in bronchial drainage; it helps to keep the thorax flexible; it enables some patients in the daytime to get along without mechanical methods of ventilation. Adequate strength and normal function of tongue, cheeks, mouth, soft palate, larynx, and pharynx are essential for this type of breathing.

SOME PSYCHOLOGICAL FACTORS OBSERVED IN POLIOMYELITIS PATIENTS

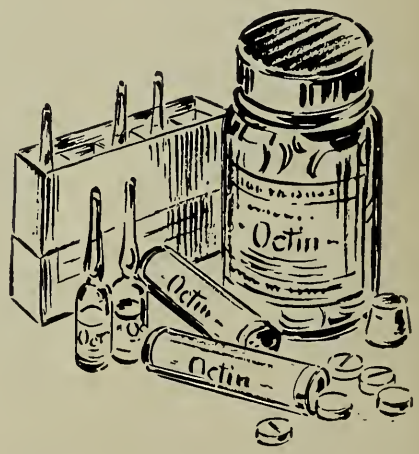
L. McCarty Fairchild, M.D. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:4:276, August 1952.

Poliomyelitis, by the nature of the disease process and its sequelae, creates a high degree of anxiety, dependency, and hostility. Under-

(*Continued on page* 54)

Octin - *for Relief of Smooth Muscle Spasm*

Octin is an antispasmodic with both neurotropic and musculotropic action indicated for the treatment of smooth muscle spasm, particularly in spastic conditions of the genito-urinary and gastrointestinal tracts. It acts promptly and the relaxation usually lasts three to five hours.



DOSE: Orally, one tablet (2 grains Octin mucate) every three to five hours.

Intramuscularly, ½ to 1 cc. (1 cc. ampule, 0.1 Gm., Octin HCl.) every three to four hours.

Octin, methylisooctenylamine, Trade Mark Bilhuber.

Bilhuber-Knoll Corp. Orange, N. J.



a broad spectrum dietary supplement

When anorexia interferes with the intake of needed foods in adequate amounts, the resultant effect on the nutritional status of the patient is considerably more apt to involve deficiency in several nutrients than in one particular nutrient. In consequence, unpredictable subclinical deficiency states may arise, which can seriously impede convalescence. Hence when anorexia is present, it is good prophylactic therapy to prescribe a dietary supplement of broad nutrient spectrum, capable of improving the intake of virtually all indispensable nutrients.

The dietary supplement Ovaltine in milk enjoys long-established usage in clinical practice. As is evident from the appended table, it supplies notable amounts of virtually all nutrients known to take part in metabolism. Its biologically complete protein provides an abundance of all the essential amino acids. It is delightfully palatable, easily digested, bland, and well tolerated.

Ovaltine is available in two varieties, plain and chocolate flavored, giving choice according to preference. Serving for serving, both varieties are virtually alike in their wealth of nutrients.

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Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	260 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Knox Gelatine . . . useful protein supplement in health and disease

Necessary for Nitrogen Balance

Good dietary practice admits of an optimum protein intake of about 100 grams per day with a minimum of not less than 1 gram per kilo of body weight. At least half of the protein should be of first class biologic value, the remainder furnished in a readily assimilable form the 14 or more synthesizable amino acids necessary for nitrogen balance.

Excess Protein Assured

Since large amounts of whole protein are necessary to assure a margin of safety for varied metabolic needs, an excess of protein intake is assured through the use of Knox Gelatine Drink daily. One envelope of Knox Gelatine readily prepared with fruit juice, water or milk, as the patient desires, provides 7 grams of gelatine of which 85 per cent is pure protein.

For Optimal Health

Since protein is not stored in the body, the daily catabolic needs and any extraordinary requirements must be taken care of daily, in order to assure optimal health.

Glycine and Proline Important

Knox Gelatine is a valuable protein supplement, easy to digest and administer as well as being non-allergenic. Knox Gelatine contains important glycine and proline necessary for hemoglobin formation. It has a high specific dynamic action, spares essential amino acids and furnishes amino acids for the continuous dynamic exchange of nitrogen in the tissues.[1]

1 Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

You are invited . . to send for brochures on diets of Diabetes, Colitis, Peptic Ulcer . . . Low Salt, Reducing, Liquid and Soft Diets. KNOX GELATINE, JOHNSTOWN, N. Y. DEPT. IL

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All Protein No Sugar



Physical Medicine (Continued)

standing and early proper management of these psychological factors prevent secondary neurotic complications and facilitate achievement of maximum rehabilitation.

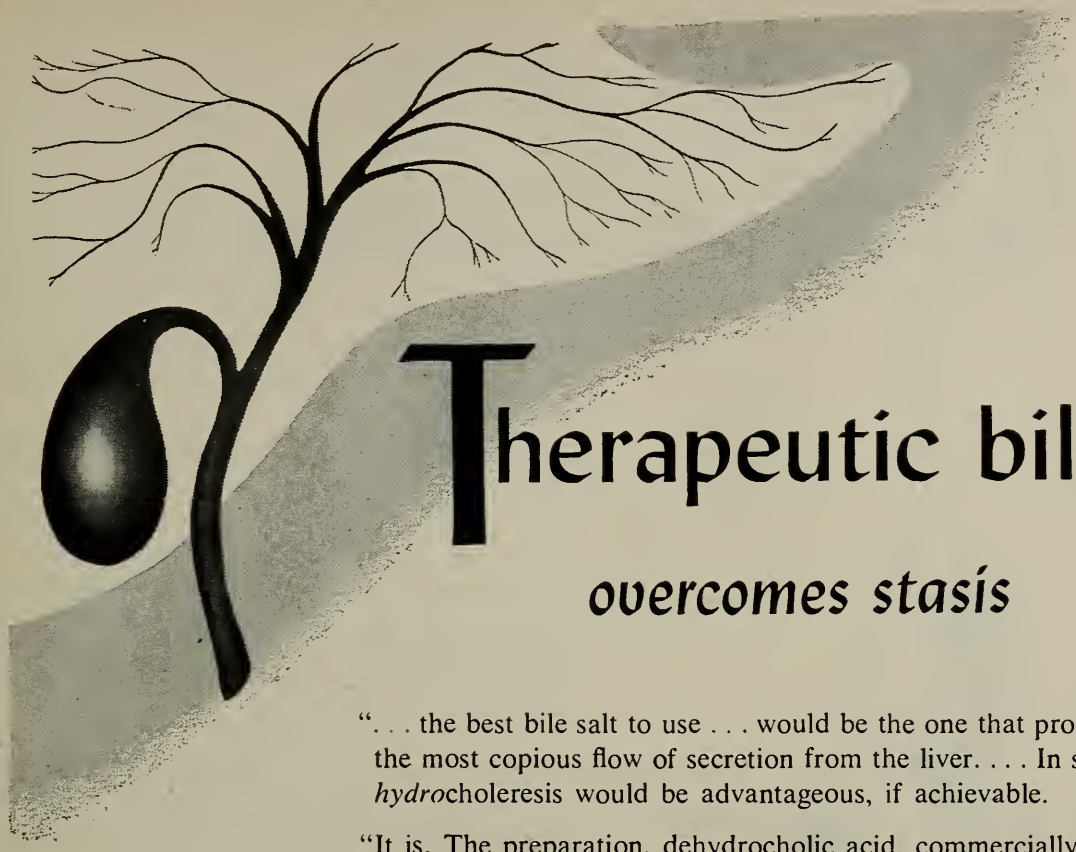
From a psychological viewpoint, what is done during the early acute phase of the illness may be of crucial importance. Patients rapidly sense and secure support from a treatment regime that is efficiently organized. This regime begins in the admitting service.

Poliomyelitis strikes quickly. Public awareness of the potential damage and the knowledge that a specific cure is not available produces marked anxiety. Rapid loss of motor function also creates fear. The total situation is one in which a tremendous amount of anxiety is thrust upon the patient in a short period of time. The resulting psychological picture frequently resembles the reaction to catastrophe. Appropriate management follows recognition of this situation.

The most basic reaction to an anxiety-provoking situation is either to attack or flee the threat. Patients with poliomyelitis are not in a position to elect flight. When flight is blocked, attack is the only remaining alternative, which is merely reinforced by the loss of motor function. Therefore, in poliomyelitis the tendency toward hostile reactions is potentially great. This hostility is essentially primary to the situation created by the disease.

Whenever the number of hospitalized poliomyelitis patients permits, they should be handled on a separate service. The attending staff should be more or less permanent and not rotate at short intervals, because the security derived by the patient from the staff is of great importance. This support can be achieved only if continuous contact is maintained with the same personnel. When a change or disruption in this relationship is necessary, the patient should be prepared in advance for the change. Poliomyelitis patients requiring protracted hospital care should not be scattered through a general hospital service which is organized to care for acute illnesses of relatively short duration, for the needs of chronically ill patients are different from those of acutely ill individuals.

(*Continued on page* 56)



Therapeutic bile

overcomes stasis

". . . the best bile salt to use . . . would be the one that produced the most copious flow of secretion from the liver. . . . In short, *hydro*choleresis would be advantageous, if achievable.

"It is. The preparation, dehydrocholic acid, commercially available as Decholin . . . does considerably increase the volume output of a bile of relatively high water content and low viscosity. The drug is not a cholagogue, i.e., it does not promote evacuation of the gallbladder, but it is a good 'flusher'."*

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dehydrocholic acid, Ames



*Hydro*choleresis with *Decholin* produces abundant, thin, free-flowing bile—"therapeutic bile." This flushes thickened bile, mucus plugs and debris from the biliary tract.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (sodium dehydrocholate, *Ames*) 20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc.

*Beckman, H.: Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders Company, 1952, p. 361.

Decholin and *Decholin Sodium*, trademarks reg.

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[ORAL FAT EMULSION SCHENLEY]

• **provides extra calories**—150 per ounce, in easily utilized form, for quick gain in weight and strength

• **without excessive bulk**—no undue digestive burden...no reduction in appetite for other foods

• **or cloying taste**—delicious alone or with a variety of nutritious foods

In 16-oz. bottles.

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Physical Medicine (Continued)

MUSCULAR RELAXATION AS A THERAPEUTIC PROCEDURE

A. B. Gottlober, Ph.D., Los Angeles. In ANNALS OF WESTERN MEDICINE AND SURGERY, 6:9:575, September 1952.

Never in the recorded history of man was there ever a time when the need for relaxation was as urgent as it is today. Yet essential as this practice is to mental and physical health, very few people have a true conception of what it is or how it functions. The usefulness of relaxation as a therapeutic procedure has been demonstrated repeatedly. A great many organic disorders such as those involving the digestive and circulatory systems have shown improvement with this method of treatment when drugs and other medical procedures have failed; and relief from symptoms of neurotic origin has been accelerated when relaxation therapy was given concurrently with psychotherapy.

Telling a patient to relax is not enough. He must be taught. He cannot be expected to learn by himself. There is a certain definite procedure to follow in which he must be instructed. He must be shown where his greatest tensions occur, how to recognize them and how to release them. He must be motivated and kept at the task until he reaches his goal.

Almost anyone of normal intelligence, regardless of age, can be taught muscular relaxation provided he is willing to cooperate for a sufficient period of time, which varies with the individual.

Muscular relaxation has been definitely established as an effective therapeutic procedure in a number of mental and physical disorders, such as muscle pain, indigestion and spastic colon, high blood pressure, nervous disorders, speech disorders and sleep irregularities.

Where we were once content to diagnose bronchogenic carcinoma rarely, tuberculosis only in the moderately advanced stage, and bronchiectasis by such late signs as cavernous breathing at the base, fixation of the chest, and cyanosis, we have advanced to the point where they can detect these diseases in the earliest stage. Drugs have been discovered that have brought many of the deadliest diseases under the therapeutic yoke. The antibiotic age has permitted an ever increasing application of surgical measures whereby irreversibly diseased tissues have been excised easily, fearlessly, and successfully. J. Winthrop Peabody, M.D., The J.A.M.A., Dec. 13, 1952.

"...for the first time in his life he developed a real appetite."

Here is a case history from a Philadelphia Pediatrician. It illustrates the clinical results achieved with 'Trophite' in below-par children:

Patient: Jim B., age 12, height 55 inches, weight 75 pounds. ". . . had been a very marked feeding problem since birth . . . was always called the 'runt' . . . a psychological problem."

Treatment: "He was started on 'Trophite' and for the first time in his life he developed a real appetite." One teaspoonful of 'Trophite' daily for 2 years.

Results: During first year he gained 13 pounds and grew 3 inches. "His appetite continued to improve . . ." At the end of 2 years he weighed 108½ pounds and was 63½ inches tall—a total gain in weight of 33½ pounds and increase in height of 8½ inches.

Comment: ". . . no longer the 'runt' in his class . . . a much happier and better adjusted child."

Smith, Kline & French Laboratories, Philadelphia

Trophite* — B_{12} plus B_1

to increase appetite and growth in below-par children

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BOOK REVIEWS



STANDARD VALUES IN BLOOD Being the first fascicle of a Handbook of Biological Data: Edited by Errett C. Albritton, A.B., M.D., Fry Professor of Physiology, The George Washington University. Prepared under the Direction of the Committee on Handbook of Biological Data American Institute of Biological Sciences, The National Research Council. 199 pages. Philadelphia and London: W. B. Saunders Company, 1952. Price $4.50.

This is the first fascicle of a Handbook of Biological Date being prepared for the National Research Council. It is a compact volume in tabular form containing the more basic established data on the composition and reactions of blood in man and animals.

By using a system for presenting bibliographic references adapted from that used in geographic atlases, there is a saving of space which permits use of a larger type face in each table. In addition to the advantage of a gain in readability, this offers a useful, up to date grouping of references.

This handbook should prove to be of value in any clinical laboratory or library.

J. C. S.

A TEXTBOOK OF CLINICAL PATHOLOGY: Edited by Seward E. Miller, M.D., Medical Director, United States Public Health Service; Chief, Division of Occupational Health, Washington, D. C. Fourth Edition. Baltimore, The Williams & Wilkins Company, 1952. 1060 pages. $9.00.

The fact that this book has had four editions and six reprintings since its first appearance in 1938 reflects its popularity with physicians and medical students, for whom it is intended. This latest edition has been carefully redesigned with emphasis on the fundamentals of laboratory diagnostic procedures. Details of technic are left to other tests.

The book is well organized and written. The illustrations are excellent. The index is adequate.

It is recommended for laboratory librarians.

J. C. S.

OPERATING ROOM TECHNIC (Fourth Edition): By St. Mary's Hospital, Rochester, Minnesota. 345 Pages with 219 figures. Philadelphia and London: W. B. Saunders Company, 1952.

The Fourth edition of this most complete work for operating room supervisors and nurses has been entirely rewritten to keep pace with new surgical procedures.

Each standard operation is outlined, with position, drapes, instruments, drains and sutures clearly enumerated. There are excellent drawings, photographs and illustrations.

J. W. P.

SIDE EFFECT OF DRUGS: by L. Meyler, Consulting Physician at Groningen (Netherlands) translated by PH. Vuijsje and W. Mulhall Corbet, Amsterdam. 268 pages — Elsevier Publishing Company — 1922.

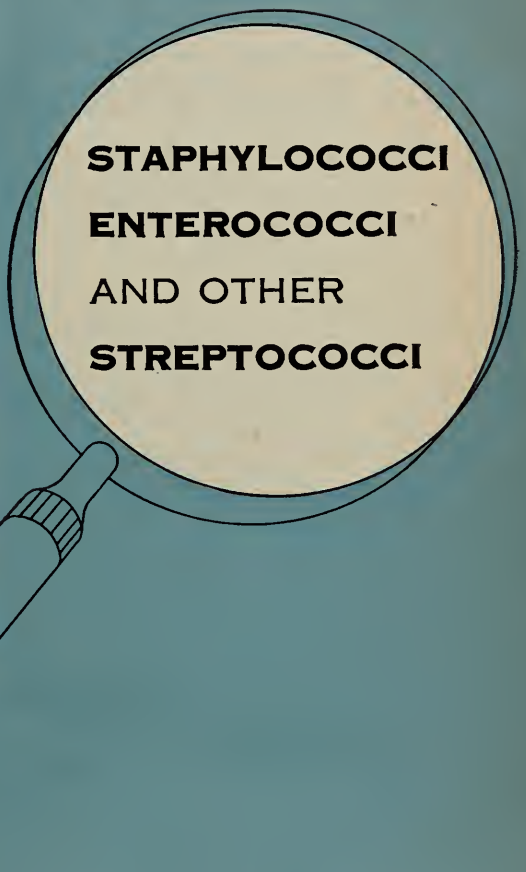
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(*Continued on page* 66)

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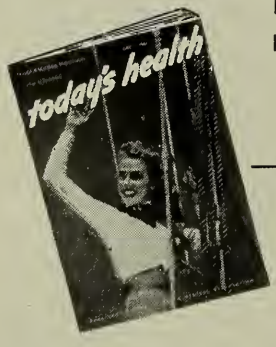
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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HANDBOOK OF ORTHOPAEDIC SURGERY: By Alfred Rives Shands, Jr., B.A., M.D., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation, Wilmington, Delaware; Visiting Professor of Orthopaedic Surgery, University of Pennsylvania School of Medicine, Philadelphia. In collaboration with Richard Beverly Raney, B.A., M.D., Professor of Surgery in Orthopaedic Surgery, University of North Carolina, Chapel Hill, N. C., Lecturer in Orthopaedics, Duke University School of Medicine, Durham, N. C. Illustrated by Jack Bonacker Wilson and others. Fourth edition. The C. V. Mosby Company, 1952, St. Louis. Price $8.00.

AMERICAN POCKET MEDICAL DICTIONARY: A Dictionary of the Principal Terms Used in Medicine, Nursing, Pharmacy, Dentistry, Veterinary Science, and Allied Biological Subjects. New, 19th Edition. 639 pages. Philadelphia and London: W. B. Saunders Company, 1953. Price $3.25 plain; $3.75 with Thumb-Index.

USE OF ANTIBIOTICS IN TROPICAL DISEASES: Annals of the New York Academy of Sciences, Volume 55, Art. 6. Pages 967-1284. Editor, Roy Waldo Miner. Consulting Editor, H. W. Brown. Published by the Academy, December 30, 1952. 318 pages, illustrated. $4.00.

MEMBERSHIP ROSTER, AMERICAN COLLEGE OF CHEST PHYSICIANS, 1952. 8th edition.

A DOCTOR'S SOLILOQUY. By Joseph Hayyim Krimsky. Philosophical Library, New York. 116 pages. Price $2.75.

CLINICAL ALLERGY. By French K. Hansel, M.D., M.S., Director, Hansel Foundation for Education and Research in Allergy; Chief of Allergy Service, DePaul Hospital, St. Louis. With 86 illustrations and 3 color plates. The C. V. Mosby Company, St. Louis, 1953. Price $17.50.

PRACTICE OF PSYCHIATRY. By William S. Sadler, M.D., F.A.P.A., Chicago, Consulting Psychiatrist to Columbus Hospital and Pinel Sanitarium; Fellow of the American Psychiatric Association; Member of the American Psychopathological Association. The C. V. Mosby Company, St. Louis, 1953. Price $15.00.

HOSPITAL STAFF APPOINTMENTS OF PHYSICIANS IN NEW YORK CITY: Hospital Council of Greater New York. The MacMillan Company, New York, 1951. 151 pages. Price $3.25.

THE ANATOMY OF THE NERVOUS SYSTEM: Its Development and Function: By Stephen Walter Ranson, M.D., Ph.D., Late Professor of Neurology and Director of Neurological Institute, Northwestern Uni-

(*Continued on page* 66)

Meat...

and the Weight Reduction Diet in Cardiac Disease

The important relationship between obesity and the outlook in cardiac disease and hypertension is vividly emphasized in a recent publication of The American Heart Association.*

For reasons not entirely understood at present, "heart disease and high blood pressure are more common in overweight persons than in those of desirable weight." The predisposition to atherosclerosis in obesity and the increased physical burden of carrying excess weight are undoubtedly contributing factors. Hence, as this publication points out, weight reduction is the first line of defense in decreasing the incidence of cardiac disease, and in improving the prognosis after cardiac disease or hypertension has developed.

Meat occupies a prominent position in the weight reduction diets outlined in this American Heart Association booklet. This recommendation is in sharp contrast to the erroneous belief held in former years that meat is harmful in hypertension or cardiac disease. "There is no evidence that red meat or any other form of protein in moderation has any adverse influence on blood pressure."

The magic formula for reducing is simply "Eat less." Two types of diets are outlined. One "allows moderate amounts of meat and other proteins, small amounts of fat and moderate amounts of carbohydrates." The other is "high in protein with plenty of meat, eggs and cheese, moderate in fat and low in carbohydrates." Diet No. 1 provides 70 Gm. of protein, 60 Gm. of fat, and 120 Gm. of carbohydrate; caloric yield, 1,300. Diet No. 2 provides 100 Gm. of protein, 80 Gm. of fat, and 60 Gm. of carbohydrate; caloric yield, 1,360.

The inclusion of generous amounts of meat in these diets—12 to 16 ounces of cooked meat or two substantial servings each day in Diet No. 2—is a reflection of the important role meat plays in any weight reduction regimen. It is generously included because of its high content of protein of excellent biologic value and because lean meat contains unobjectionably small amounts of fat.

*Food For Your Heart, a Manual for Patient and Physician, Department of Nutrition, Harvard School of Public Health, Harvard University, The American Heart Association, Inc., New York, 1952. Copies available through local Heart Association.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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BOOKS RECEIVED (Continued)

versity Medical School, Chicago. Revised by Sam Lillard Clark, M.D., Ph.D., Professor of Anatomy, The Vanderbilt University School of Medicine, Nashville. New, 9th Edition. 581 pages with 434 illustrations, 18 in color. Philadelphia and London; W. B. Saunders Company, 1953. Price $8.50.

A Manual of Clinical Allergy: By John M. Sheldon, M.D., Professor of Internal Medicine, University of Michigan Medical School; Robert G. Lovell, M.D., Instuctor in Internal Medicine, University of Michigan Medical School; Kenneth P. Mathews, M.D., Assistant Profesor of Internal Medicine, University of Michigan Medical School. 413 pages with 27 figures. Philadelphia and London: W. B. Saunders Company, 1953. Price $8.50.

Gifford's Textbook of Ophthalmology. By Francis Reed Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School. Consulting Surgeon, Wills Eye Hospital, Philadelphia. New, 5th Edition. 488 pages with 281 figures and 26 color plates. Philadelphia and London: W. B. Saunders Company, 1953. Price $7.50.

Treatment of Mental Disorder: By Leo Alexander, M.D., Director, the Neurobiological Unit, Division of Psychiatric Research, Boston State Hospital, and Instructor in Psychiatry, Tufts Medical School. 507 pages with 143 figures. Philadelphia and London: W. B. Saunders Company, 1953. Price $10.00.

The Basis of Clinical Neurology, The Anatomy and Physiology of the Nervous System in Their Application to Clinical Neurology. By Samuel Brock, M.D., Professor of Neurology, College of Medicine, New York University. Third Edition. The Williams & Wilkins Company, Baltimore, 1953. $7.00.

Atlas of Medical Mycology. By Emma Sadler Moss, B.S., B.M., M.D. and Albert Louis McQuown, B.S., B.M., M.D. Williams & Wilkins Company, Baltimore, 1953. 245 pages. $8.00.

Poliomyelitis. Papers and Discussions Presented at the Second International Poliomyelitis Conference. Compiled and Edited for the International Poliomyelitis Congress. J. B. Lippincott Company, Philadelphia, London and Montreal. 555 pages. $7.50.

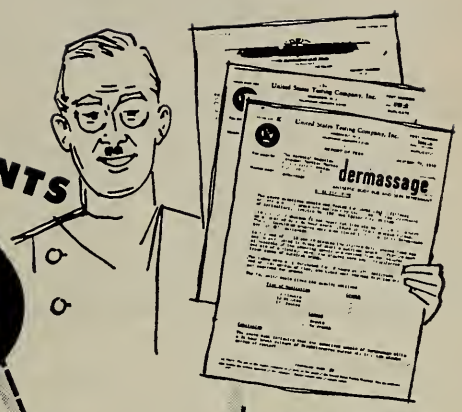
Oral Anatomy. By Harry Sicher, M.D., D.Sc., Professor of Anatomy and Histology, Loyola University School of Dentistry, Chicago College of Dental Surgery; Guest Lecturer, Northwestern University, Dental School, Chicago. With 310 text illustrations, including 24 in color. Second edition. The C. V. Mosby Company, St. Louis. 529 pages. $13.50.

Diseases of the Esophagus. By Philip Thorek, M.D., F.A.C.S., F.I.C.S., Associate Clinical Professor of Surgery, University of Illinois College of Medicine, Professor of Esophageal Diseases and Clinical Surgery, Cook County Graduate School of Medicine, etc. 102 illustrations. Drawings by Carl T. Linden, Assistant Professor of Medical Illustration, University of Illinois College of Medicine. J. B. Lippincott Company, Philadelphia. $10.00.

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All cases of complete pracenta previa must be treated by cesarean section, regardless of parity. This is also the best therapy for partial previa in a primipara. In a multipara with a well effaced and dilated cervix, labor may be initiated by rupturing the membranes. If the cervix is not ripe, cesarean section is the method of choice. Cesarean section is less justified in cases with a low implantation of the placenta if the cervix is sufficiently dilated to permit vaginal delivery. Rupture of the amniotic sac with release of the amniotic fluid after a shorter or longer delay will initiate labor. Intravenous administration of Pitocin insures the rapid onset of labor. No attempt at inducing or terminating the pregnancy should be made before the blood level is restored to normal. Application of Willett forceps to the vertex is effective in the control of persistent bleeding. For the inexperienced obstetrician treating a case of placenta previa, abdominal hysterotomy usually is the safest procedure. There is no doubt that vaginal delivery increases the likelihood of cervical and lower uterine lacerations, as these structures are extremely friable when a placenta previa exists. The increased bleeding may not be easy to control, as repair of the laceration sometimes offers difficulties. Occasionally such a delivery may culminate in a hysterectomy for the control of bleeding — at best, not a gratifying result. Obstetricians now agree that Braxton-Hicks version, metreurysis, or packing of the vagina should never be carried out in treating placenta previa; these procedures are traumatic and predispose to infection and prolapse of the umbilical cord. *Archie A. Abrams, M.D. Bleeding in the Last Trimester of Pregnancy. Boston M. Quarterly, Sept. 1952.*

The education of the patient is essential not only for the patient's own welfare and protection of his family, but also for the protection of the staff. We believe every nurse is a teacher. With the tuberculous patient education must begin with his diagnosis, and be continuous throughout his care. The nurse must appreciate the fact that education about his illness is an integral part of nursing care of the tuberculosis patient. Miss Aileen Flett, Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.

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The data suggest that if heredity plays a role in rheumatic fever, it is perhaps one of inherited susceptibility, not strictly predictable because of an important controlling factor in the occurrence of the disease — namely, repeated infections due to the beta-hemolytic streptococcus. It might be speculated that the inherited factor may not be an increased susceptibility to rheumatic fever per se but rather an altered host response to repeated infection, the latter being enhanced or becoming recurrent within the family circle when poor housing and crowding in the home are present. *Frieda G. Gray, M.D. et al, A Long-Term Survey of Rheumatic and Nonrheumatic Families. Am. J. Med., Oct. 1952.*

The problem of caring for the aged, sick person is likely to become serious in spite of preventive programs. It is an overwhelming medical and hospital issue even today when three out of every four hospital beds are occupied by victims of long-term illnesses, including mental and tuberculous. A. P. Merrill, M.D., N.Y.S. Med. J., Oct. 1, 1952.

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THE PHYSICIAN AND THE REPORTER

The public's right to information in a field so intimately linked with its happiness imposes certain moral obligations on both writer and doctor, Mr. Bach (Director of Press Relations for the American Medical Association) thinks. The doctors must rid themselves of the notion that a journalist will never get anything right, recognizing that science writers are as well trained for their specific jobs as the doctor is in his field, and are, by and large, people of competence and integrity. In his own area, the science writer is a specialist. And, as Mr. Bach adds, "All of these writers work for an institution or a business whose freedom is guaranteed under the Constitution of the United States and all of the state constitutions. Under such guarantees, the press stands by common consent first among the organs of public opinion. A reporter's job is to report news accurately and impartially, and if he is working on a medical story he naturally turns to the doctor for the facts. He should turn to the medical profession for his information because, naturally, it is the best informed and should always be considered the authoritative source. The facts about American medicine and the health of the American people have to be told by those who know them. If the reporter cannot get the facts from you, the doctor, he will go elsewhere and the chances of the medical profession for getting an accurate story before the public will be lost." *Editorial, The Profession And The Fourth Estate. GP., Oct. 1952.*

RICKETTSIALPOX

In June, 1946, a new illness was observed in the residents of a housing development in the Borough of Queens in New York City. The disease, originally referred to as Kew Gardens' spotted fever, quickly became epidemic in the area and at the same time similar cases were reported from other parts of New York City. The disease was subsequently identified as a new entity caused by a newly discovered species of rickettsia. Because some of the lesions were papulovesicular and confused with varicella the disease was named rickettsialpox and the causative organism was designated R. akari. Epidemiologic and entomologic studies later demonstrated that the primary host of the infection was the common house mouse (Mus musculus)

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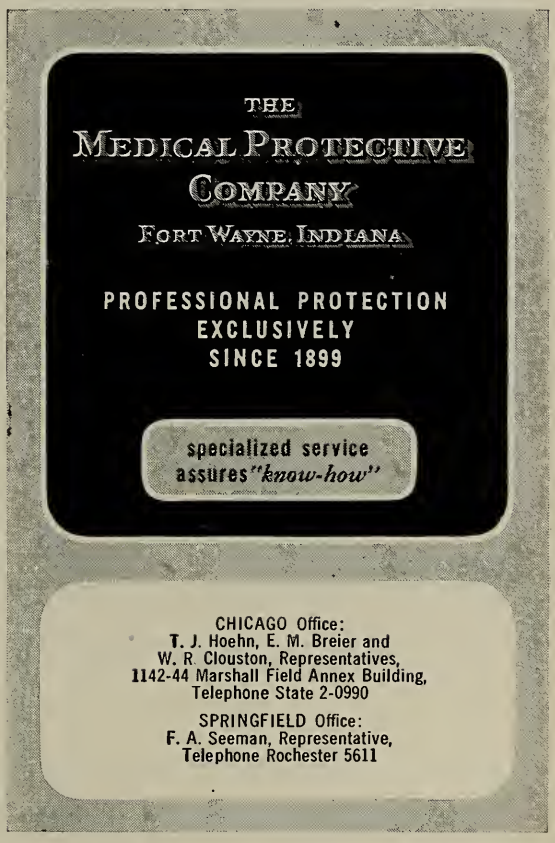
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and that the organism was transmitted to man accidentally by a blood-sucking rodent mite (Allodermanyssus sanguineus). Since the recognition of the disease in 1946, about 150 cases a year have been reported to the New York City Department of Health. The first published report of a case outside New York City, in a resident of Boston, Mass., recently appeared. *Alfred C. LaBoccetta, M.D. et al. Rickettsialpox. Am. J. Med. Oct. 1952.*

Tuberculosis is a special hazard to the person who has a severe form of diabetes, particularly to the diabetic who is under forty. Some workers believe that the increased susceptibility of the diabetic to tuberculosis is due to a disturbance of protein and fat metabolism. David A. Cooper, M.D., and Katharine Boucot, M.D., The American J. of Nursing, Nov., 1952.

Although tuberculosis is the primary concern of community-wide chest X-ray surveys, the screening programs do identify other pathological conditions of the chest, including thoracic neoplasms and cardiovascular abnormalities. In view of our aging population, this is assuming greater value as a by-product of tuberculosis case-finding projects. Robert J. Anderson, M.D., The J.A.M.A., Feb. 23, 1952.



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The importance of individual education of the diagnosed tuberculous patient in the meaning of his illness cannot be stressed too strongly. The average patient is impressed only by symptoms or by definite statements from a physician. Howard M. Payne, M.D., Philip Enterline, and Julia Heuck, The American Review of Tuberculosis, Nov., 1952.

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MAKEUP OF PHYSICIANS

In the final analysis the conclusions to be drawn from the report (The Cost of Health. London, Turnstile Press, 1952) are that the composite physician, a somewhat temperamental and insecure individual, mingles in his makeup idealism, secretiveness, a sense of importance, a love of the feeling, at least, of power, and a fear of that socialization of his activities that might tend to destroy his cherished individualism. *Editorial, Unfinished Business. New Eng. J. Med., Sept. 11, 1952.*

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Janney, J.C.: Medical Gynecology, ed. 2, Philadelphia, W.B. Saunders Co., 1950, p. 365.

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Vol. 103, No. 4 April, 1953

THE 1953 ANNUAL MEETING

The 1953 Annual Meeting of the Illinois State Medical Society will be held at the Hotel Sherman, Chicago, on May 19-22. This year with a four day session, the arrangements are somewhat different than those in recent years. Individual Section meetings will be conducted Tuesday and Wednesday morning, then there will be general assembly sessions beginning Wednesday afternoon and until the end of the meeting on Friday afternoon.

Information and program for the meeting are published in this issue of the Illinois Medical Journal, and it is hoped that every member will look it over carefully, then plan to attend the 1953 annual meeting. The Woman's Auxiliary is celebrating its 25th anniversary this year, and their sessions likewise will be conducted in the Hotel Sherman.

There will be the usual array of technical and scientific exhibits this year, as well as the motion picture demonstrations scheduled throughout the entire session. The House of Delegates will hold its first meeting on Tuesday afternoon, the second meeting on Thursday afternoon, and the final session on Friday morning. Every component county medical society is entitled to representation in the House of Delegates and it is hoped that all of them will have delegates present throughout the sessions.

The Annual Meeting is the members' own meeting, and every member of the Society should arrange to be present for the 1953 session. Interns and residents also will be welcome and there is never any admission fee to these annual meetings.

ARRANGE TO BE PRESENT AT THE 1953 ANNUAL MEETING.

THE GAMMA GLOBULIN PROBLEM

Physicians throughout the country are deeply concerned over the wide publicity given to the use of gamma globulin in the prevention of paralytic poliomyelitis, as well as the proposed program for the procurement and distribution of gamma globulin. There is also alarm over the probability that its use in poliomyelitis will deplete the supply of this blood fraction for use in the prevention and modification of measles, and in the prevention of infectious hepatitis, in both of which diseases it has been proved highly effective.

The American Medical Association, recognizing the kind of situation that might develop due to this publicity, has met with other interested groups. After many conferences it was recommended last October that the Division of Medical Sciences of the National Research Council advise with the Subcommittee on Blood of the Office of Defense Mobilization on the

subject of gamma globulin for this purpose. In October a committee was set up and made the following recommendations to the Office of Defense Mobilization:

1. The preliminary evidence presented indicates that the administration of gamma globulin has limited prophylactic value from the end of the first week through the fifth week after it has been injected. The Division reserves any further judgment pending the availability of final clinical follow-up examinations and of the results of pertinent laboratory studies.

2. From the scientific point of view, it is felt that gamma globulin does not provide a practical solution to the problem of the prevention of paralytic poliomyelitis. The most promising field of investigation definitely appears to be the development of a polyvalent vaccine.

3. From the practical point of view, while every effort should be made to provide adequate amounts of gamma globulin, as an interim measure, for minimal estimated epidemic needs for poliomyelitis in the coming season, primary consideration should be given to the requirements of the Armed Services and of civil defense for whole blood and its derivatives, and of gamma globulin for the prophylaxis of measles and infectious hepatitis.

4. A further recommendation was made that every effort be made to increase the rate of fractionation of human plasma as rapidly as possible.

It is expected that all pharmaceutical companies will turn over their entire output of gamma globulin, to be distributed and allocated by a panel appointed by the National Research Council. The panel members are Dr. Hugh R. Leavell, Professor of Preventive Medicine and Public Health, Harvard University Medical School, Chairman; Dr. Thomas P. Murdock, member, Board of Trustees, A.M.A.; Dr. John D. Porterfield, Director, Ohio Department of Health; Dr. E. Bruce Underwood, State Health Commissioner of Kentucky; Dr. Alexander Langmuir, U.S. Public Health Service; Dr. James A. Shannon, National Health Institute; and Dr. William McD. Hammond, University of Pittsburgh School of Public Health.

At a meeting in March of this year, attended by all of the interested national agencies, it was decided that 20% of the available serum would be allocated to family and other intimate contacts. For this purpose a total of 40 cc. will be made available for all contacts of each diagnosed case. At the expected dose of 0.14cc per pound this will not be enough to protect anyone outside the immediate family in most cases. In fact, it will not cover all of the members of a sizeable family. The remaining 80% of available stock will be used for mass immunization in epidemic areas.

The gamma globulin now in the refrigerators of Health Departments and in the commercial houses throughout the country is effective against measles and infectious hepatitis, but has not been assayed as to its antibody titre against poliomyelitis. It is known that not all batches of gamma globulin have anti-poliomyelitis antibodies. All gamma globulin now being processed is being tested against the Lansing strain, and will shortly be assayed against the other two strains of poliomyelitis virus. Batches of serum which do not show an adequate titre will be set aside to augment the critically short supply of gamma globulin for measles and infectious hepatitis. It is important for physicians to realize that to use any gamma globulin now available for the purpose of preventing poliomyelitis will not only waste the very inadequate supply for measles, but it will put the physician in a position of offering protection against poliomyelitis with a serum which may be completely ineffective for this purpose.

The seriousness of the situation is seen by the fact that best estimates indicate that there will be available no more than 1/12 the amount needed during this spring and summer. In such a situation, tremendous pressure will be brought to bear upon physicians throughout the country by the public for the injudicious or inequitable use of the serum in the prevention of poliomyelitis. We must be alert to combat the development of any black market or stock piling of present supplies of the serum, realizing that the material now on hand is not a proper serum for use in poliomyelitis. Leaving the final decision as to the indications for the use of gamma globulin, and as to its allocation, to a national group of experts will not only conserve the supply, but it will take the onus off of the local physician.

THE NEW ENZYMES

Tryptar® and Varidase® are valuable adjuncts in the treatment of empyema, necrotic empyema, necrotic ulcerations, infected wounds, and hematomas. Debridement is based upon selective enzymatic digestion of non-viable cells and tissues and in this way some of the impediments to healing are removed and a clean operative field is produced. In empyema, the thick, viscid, purulent fluid changes rapidly into a tawny, watery fluid that is easily removed. The more recent use of aerosol trypsin opens up a new avenue of approach to the treatment of chronic lung disorders. Sputum changes occur and there is increased weight and appetite as well as improvement in sleep and the general feeling of well being following prolonged administration of the material. Sleep is especially improved in patients who had severe productive coughs prior to treatment. In some instances, positive sputum for tuberculosis has shown a marked decrease in the number of tubercle bacilli in the sputum. In bronchiectasis there may be prompt relief of cough, decreased dyspnea, and an increase in vital capacity.

1952 BLUE SHIELD REPORT

The Board of Trustees of Illinois Medical Service has recently directed that the following brief resume of the past year's activities of its Blue Shield Medical-Surgical Plan be released for publication.

During the past year the assets of the Corporation increased from $2,882,962 to $4,749,092 . . . an increase of $1,866,130, or 64%. The reserve for future medical care (unallocated reserve) was increased through the addition of $766,016, making a total at the end of the year of $2,406,622. This reserve, when applied to our membership, provides a per member reserve of $3.04, placing it among the highest in the field.

In addition to this reserve for future medical care, a further reserve factor of $1,698,000 is provided for those claims not received and unreported. Using the average monthly claim payment factor, this reserve provides for 4-½ months of additional liability.

Income from members increased 38%, from $4,918,783 during 1951 to $6,818,829 during 1952. During this same period the cost of operating the Plan decreased to 11.57% of income.

In 1952 a total of 82,365 claims were paid, representing an increase of 24,750 cases over the preceding year. Allowances totaling $5,308,836 were paid or provided for services of 7,927 physicians. This amount represents an increase of $1,858,525, as compared with $3,450,311 in the previous year. At the end of 1952 the enrolled membership of the Plan was 790,486 as compared with 584,436 at the end of 1951 . . . a net increase of 206,050 for the twelve month period, or 35%.

Under arrangements with participating physicians in this State, Illinois Medical Service has been authorized to continue to make its services available in 97 counties throughout the State of Illinois.

GLAUCOMA—WHAT THE GENERAL PRACTITIONER SHOULD KNOW

Above is the title of a sound film in color, presented by the National Society for the Prevention of Blindness. Prepared under the scientific direction of the National Society's Committee on Glaucoma. It is available without charge except for transportation.* It is suited for showing to state and county medical societies, hospital staffs, etc. An ophthalmologist should be present at the showing to introduce the film and to answer questions.

This film was shown at a recent Clinical and Pathological Conference of the Illinois Central Hospital in Chicago. Over forty physicians were present. It was introduced by Dr. Kenneth L. Roper, Chief Oculist. A discussion followed the showing of the film in which Doctors Joseph E. Alfano and Donald J. Boles, Assistant Chief Oculists, also participated as well as several other members of the Staff.

The film is a twenty-two minute sound film in color which explains the mechanism of glaucoma, early signs and symptoms, which and an explanation of the rationale of treatment.

Early in the film there is a discussion of the formation and drainage of the aqueous, how intraocular pressure is maintained and the effects of increased pressure. The difference between congestive glaucoma, which may be either acute or chronic, and chronic simple or non-congestive, is explained.

*Write to Committee on Glaucoma, National Society for the Prevention of Blindness, Inc., 1790 Broadway, New York 19, N. Y.

The effect of increased pressure on various parts of the eye is shown diagrammatically. The technique of tonometry using the standardized Schiotz tonometer is briefly shown, as well as a simple test for field of vision using a white test object.

The opthalmologist is shown, using slit-lamp, gonioscope, perimeter and tangent screen. The dark-room and water-drinking tests are discussed as examples of provocative tests which the ophthalmologist may use.

Treatment is discussed briefly, with mention of miotics such as pilocarpine and eserine and with diagrams showing certain types of remedial surgery.

DISCUSSION

The term glaucoma does not connote a disease-entity, but embraces a group of pathological conditions which have as their outstanding clinical manifestation an increase in the intraocular pressure and its dire consequences.

In our present state of ignorance it is useful to admit a classification into two groups:—secondary glaucoma, wherein the symptom of raised pressure is due to some obvious ocular lesion which is known, and primary glaucoma, wherein the raised pressure is due to some unknown cause.

Glaucoma is a serious problem. It is estimated that one-eighth of the 260,000 blind men, women and children in this country have lost their sight because of glaucoma.

It can be emphatically stated that the untreated case of glaucoma will progress and result in absolute bilateral blindness. The early diagnosed case of glaucoma with adequate treatment can be stabilized and its progress delayed so that useful vision remains until the death of the patient. Certain cases of glaucoma are destined to gradually and imperceptibly go downhill in spite of adequate control of the tension. In the average case the end results depend essentially on two factors—the early recognition of the disease, and the sustained adequacy of treatment. Glaucoma is never cured, but arrested. Once diagnosed a patient, must be given to understand that it will be with him as long as he lives and that constant observation and eternal vigilance must be maintained, so that any change in his condition may be met by a change in the medical treatment or by a surgical attack. In chronic simple glaucoma with reasonably adequate treatment 70 percent of cases do well in so far as they become stabilized, 20 percent deteriorate so slowly that they retain a useful amount of sight to the end, while 10 percent do badly.

The general practitioner is in the most strategic position to help in the control of blindness, from glaucoma, since he sees these patients earlier and more frequently than the opthalmologist. Too often patients go to the ophthalmologist after considerable sight has been lost, which is too late.

The Physician should be suspicious when:

1. The vision is blurred or "smoky."
2. Close work bothers despite *frequent changes of glasses.*
3. There are halos or rainbows around lights.
4. There is eye pain after movies, dim lights, emotional upsets.
5. There is a family history of glaucoma.

Physicians should never neglect to check the following:

1. Vision—use the Snellen visual acuity chart at 20 feet (easily obtainable from A.M.A. headquarters).
2. Pupil—it is dilated and reacts slowly in glaucoma.
3. Look at the optic nerve with the opthalmoscope—it is "cupped" and pale in established glaucoma.
4. Tension—become adept in feeling the tension of the eyeballs when the patient looks down.
5. Fields—inquire as to the patient's side vision.

Important consideration should be given to the patient who comes in with a "red eye." Most physicians when they see a "red eye" think only of conjunctivitis or iritis. Have the patient look at the ceiling, shine a light in his eyes, and if the pupils are fairly equal and react readily he is not in serious trouble. The patient with a "red eye" might easily have conjunctivitis, iritis or glaucoma. In conjunctivitis the pupil will appear normal in size and compare favorably with the fellow eye as to size and reaction to light. In iritis the pupil will be reduced in size and will not compare favorably with the fellow eye as to size and reaction to light. In glaucoma the pupil is usually dilated and will not compare favorably with the fellow eye as to size and reaction to light. In other words, if

you find the pupils are not equal the patient is probably headed for trouble.

Another important point with the handling of a "red eye": if you feel you are confronted with a case of iritis, do *not* take the responsibility of instilling atropine into the eye. You might be inadvertently instilling atropine in an eye with glaucoma with disastrous results. Nor should a general practitioner be guilty of instilling atropine into a patient's eye following the removal of a typical foreign body and thereby disable the individual for as much as a week. Atropine for use in the eyes should remain the province of the ophthalmologist. It would be well if the atropine solutions and ointments in all general hospitals were to be locked up with the narcotics.

Acute congestive glaucoma in some instances may be confused with digestive upsets or other acute intra-abdominal conditions because of the nausea, vomiting, general depression and fever sometimes produced along with the severe pain of congestive glaucoma.

I would like to emphasize again the fact that early chronic simple glaucoma should be suspected when a patient complains of vague feelings of eye discomfort, has changed his glasses frequently, has discomfort after attending the movies or watching television. Possibly 75 percent of the glasses worn by people today are prescribed by optometrists and the instances of frequent change of glasses are apt to be found in this group. This is one source of undiagnosed chronic glaucoma that the general practitioner can be helpful in diverting to the ophthalmologist for diagnosis and treatment. Be alert to glaucoma since probably 90 percent of the early cases are insidious and nearly asymptomatic for months.

If you have a patient over 40 years of age that you wish to place on belladonna or one of the antispasmodics it would be well to discuss the case with an ophthalmologist before doing so.

Patients who have chronic simple glaucoma and are using miotics should never discontinue their "drops" when under treatment for any other condition. Discontinuing drops might result in an acute rise of tension, with permanent loss of vision.

Ophthalmologists are generally agreed that the economic status of the glaucoma patient should be carefully considered for the long range handling of his case. The fee for his periodic check-up should be reasonable. He should always be referred to a competent ophthalmologist convenient and accessible to him. No patient should be aided in neglect of his glaucoma by entrusting its supervision to an ophthalmologist many miles distant and not conveniently accessible to the patient.

Kenneth L. Roper, M.D.
55 East Washington Street
Chicago 2, Illinois

March 9, 1953

MEDICATED MUSIC

"Music exhalts each joy, allays each grief, expels diseases, softens every pain, subdues the rage and passion and the plague."
John Armstrong, The Art of Preserving Health

The relation of Medicine to Music is an old story. Even the ancients believed that there was some curative power in melody, and savages such as the African and North American aborigines used music of a primitive type as a therapeutic agent. Congreve's saying "Music hath charms to soothe a savage breast" reminds us of this.

But there is another aspect of music that the writer would like to consider. Doctor Oliver Wendell Holmes spoke of his novels as medicated novels. Why not have medicated songs or melodies? I would suggest the possibility that each medical specialty might have a song of its own, just as we have national and state songs and some occupational ones such as sailor's chanteys. It is not uncommon to have communal singing after medical banquets and there is no reason why songs with a medical tinge already in existence could not be adopted by various medical groups or indeed why new ones composed by physicians gifted in music, and there have been a good many such, should not be written.

While I have not been able to think of apt compositions for all specialties I can, having been an amateur musician of sorts and very fond of good music, make some suggestions. The *G.P's* song could be "Oh Dear! What Can The Matter Be." What could be more appropriate for *Neurologists* than Arthur Sullivan's "The Lost Chord"? Not only is the title significant but Adelaide Proctor's words have a suggestive sound: "Weary and ill at ease" and "fingers

wandering idly over the well-worn keys". They really have an ataxic implication. The *Pediatricians* might choose that air from the Merry Widow: "Every Little Movement has a Meaning of its Own". What could be more appropriate for the *Ophthalmologists* than the Star Spangled Banner, the title of which suggests Muscae Volitantes, and the words of which begin "Oh Say Can You See? The *Obstetricians* have several choices: "Rockabye Baby," for example, or "Oh Blessed Night Hymeneal" from Romeo and Juliet. In some cases a less well-known song "Someone's Been Around Here While I've Been Gone" might be appropriate. The *Podiatrists* might choose Verdi's aria from The Force of Destiny "Oh Sainted Soul" or one of the old "Songs of the Corn Reapers" of northern Europe. The *Psychiatrists* could choose "What Confusion" from the Barber of Seville. Specialists in *Geriatrics* could have "Silver Threads Among the Gold", and the physicians caring for *Alcoholics* might adopt Ben Jonson's Ode to Celia which begins "Drink to Me Only with Thine Eyes". "Crossing the Bar" would, of course, be barred. The physicians in charge of institutions for the *Feebleminded,* in which the inmates frequently have their own band, could call for "Oh Little Thought" from Mignon or set to music Bret Harte's "Songs without Sense". The *Proctologists* might choose Kingsley's "Three Fishers" and the *Hematologists* Suckling's "Why so Pale and Wan". Richard Edwards' Song to the Lute might suit the *Cardiologists* for it begins "Where Griping Griefs the Heart Would Wound", appropriate in these days of psychosomatic medicine. Specialists in *Diabetes* could adopt Cowper's To a Young Lady which begins with "Sweet Stream" and might also designate the sweet pea as their favorite flower. For the *Gastroenterologists* Hamlin Garland's "Do You Fear the Wind" might be set to music, and for the *Anatomists* Locker-Lampson's "The Skeleton in the Cupboard" might be so treated. But the writer is not the only one who can make suggestions along these lines. There are many physicians with a profounder knowledge of music and if a SEMM (Society for the Encouragement of Medicated Music) should be founded, it would serve as a medium for the enhancement of these ideas.

G.B.

Member of the Society for the Liberation of Captive Balloons

FEMALE MANPOWER

During the past decade or more, demands on industry have been so great it has been necessary to draw additional workers from all sources. Handicapped persons, adolescents, and older workers have been hired but women offer the chief manpower reserve. They have proved so satisfactory that many jobs are engineered to eliminate the need for sheer strength, in order to attract the fair sex. In fact we know that most jobs can be performed satisfactorily by women. They are no more susceptible than are men to occupational disease or industrial injuries. To minimize fatigue it is advisable to adjust the machines and benches to suit the female worker.

On the other hand, Dr. M. N. Newquist, Medical Director of the Texas Company, New York, has produced statistics that should be considered whenever women are employed. They are absent three times as often as men, losing 50 per cent more time. Lost time from dysmenorrhea and menopausal changes is not as great as was previously considered and such absenteeism can be reduced by appropriate medical handling. Pregnancy occurs among five per cent of the employed married women annually. Dr. Newquist believes that in suitable jobs pregnant women might work until six weeks prior to delivery but should not return to the job earlier than six to eight weeks thereafter. These young mothers usually are good workers but if the baby sitters are industrially employable, the net gain is little or nothing.

PROGRAM

One Hundred Thirteenth ANNUAL MEETING

Illinois State Medical Society

CHICAGO, ILLINOIS

May 19, 20, 21, 22, 1953

The Hotel Sherman

COMPLETE PROGRAM

Section on Eye, Ear, Nose and Throat

Parlor "O"

Chairman**William F. Hubble, Decatur**
Secretary**Earl H. Merz, Chicago**

TUESDAY MORNING, MAY 19, 1953

9:00—**"Pharmacology of the Pupil with Practical Consideration"**
ROBERT W. LENNON, Joliet

9:20—**"Bone Conduction Studies After Fenestration Surgery and Predictions of Hearing Results"**
ROBERT HENNER, Ass't Professor of Otology—University of Illinois, Chicago

9:40—**"The Principles of the Cross Cylinder and Its Uses in Refractions"**
IRVING PUNTENNEY, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago

10:00—**"Surgery of Carcinoma of the Pharynx"**
MAURICE F. SNITMAN, Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago
IRWIN D. HORWITZ, Co-Author, Clinical Assistant Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

10:20—**"Recently Recognized Syndromes Having Ocular Association"**
HAROLD F. FALLS, Professor of Ophthalmology, University of Michigan College of Medicine, Ann Arbor, Michigan

11:05—Business Meeting

11:20—RECESS to view exhibits

TUESDAY AFTERNOON, MAY 19, 1953

1:30—**"The Treatment of Typical and Atypical Facial Neuralgias"**
JOHN L. FELDMAN, Chief, Department of Otolaryngology, Quincy Clinic

1:50—**"Treatment of Lacrimal Obstruction"**
JAMES WILSON CLARK, Associate Clinical Professor of Ophthalmology, University of Illinois College of Medicine, Chicago

2:10—**"Corrosive Esophagitis"**
PAUL H. HOLINGER, Professor of Otolaryngology, University of Illinois College of Medicine, Chicago
MARVIN J. TAMARI
STANLEY H. BEAR—Co-authors

2:30—**"Ophthalmology in Rural Areas"**
MAX HIRSCHFELDER, Attending Oculist, St. Mary's Hospital, Centralia

2:50—RECESS to view exhibits

3:20—**"Diagnosis and Treatment of Secretory Otitis Media"**
PIERCE W. THEOBALD, Chicago

3:40—**"Accommodation and Its Relation to Problems in Ocular Motility"**
BEULAH CUSHMAN, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago
DEVEREAUX JARRATT, Co-Author - Department of Ophthalmology, Northwestern University Medical School, Chicago

4:00—**"Corneal Injuries"**
PAUL C. IRVINE, Chicago

4:20—**"Correction of Congenital Anomalies of the Ear"**
EUGENE L. DERLACKI, Associate, Department of Otolaryngology, Northwestern University Medical School, Chicago

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Section on Pathology

Parlor "M"

Chairman**A. R. K. Matthews, Rockford**
Secretary**Franklin J. Moore, Chicago**

TUESDAY MORNING, MAY 19, 1953

9:00—**"Present Status of Plasma Expanders"**
CONRAD L. PIRANI, Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago

"Cardiac Arrests"
MAX S. SADOVE, Professor of Surgery, Head, Division of Anesthesiology, Research and Educational Hospitals, University of Illinois, College of Medicine, Chicago

"Cellular Pathology of Viral Infections"
V. P. WYATT, Professor of Pathology, St. Louis University School of Medicine, St. Louis, Missouri

"Laboratory Aids in Endocrine Diagnosis"
H. S. GUTERMAN, Director, Department for Research in Human Reproduction, Michael Reese Hospital, Chicago

Business Meeting—Election of Officers for 1954.

●

Section on Cardiovascular Disease

Chairman**James A. Walsh, Peoria**
Secretary**Wright Adams, Chicago**

TUESDAY MORNING, MAY 19, 1953

Parlor "L"

9:00—**"The Management of Cardio-Pulmonary Failure in Kyphoscoliosis"**
HARL W. MATHESON, Peoria
9:20—**"Rehabilitation of Cardiacs"**
LOUIS B. NEWMAN, Chief, Physical Medicine and Rehabilitation, Veterans Administration Hospital, Hines
9:40—**"Indications for Mitral Valvulotomy"**
ROBERT L. GRISSOM, Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago
10:00—RECESS to view exhibits
10:30—**"Complications and Sequelae of Acute Myocardial Infarction"**
A. CARLTON ERNSTENE, Chief of Staff, Division of Medicine, Cleveland Clinic, Cleveland, Ohio
11:00—**"Cardiac Arrhythmias"**
CHAUNCEY C. MAHER, Associate Professor of Medicine, Northwestern University Medical School, Chicago
11:20—**"Some Effects of Chronic Pulmonary Disease on the Circulation and New Concepts of Treatment"**
EMMET F. PEARSON, Springfield
11:40—Question and Answer Period
Drs. Matheson, Newman, Grissom, Ernstene, Maher and Pearson

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Illinois Association of Blood Banks

TUESDAY AFTERNOON, MAY 19, 1953

Crystal Room

2:00—**"Newer Techniques of Blood Typing and Cross-Matching"**
A. M. WOLF, Michael Reese Research Foundation, Chicago
2:10—**"Sources of Error in Blood Typing and Cross-Matching and the Procedures Used in the Follow-up of Transfusion Reactions"**
I. DAVIDSOHN, Mt. Sinai Hospital, Chicago
2:25—**"Laboratory Aspects of the Diagnosis and Treatment of Fetal Erythroblastosis"**
KURT STERN, Mt. Sinai Hospital, Chicago
2:35—**"Emergency Transfusions - What Type of Blood to Use"**
COYE C. MASON, Grant Hospital, Chicago
2:45—**"Indications for Transfusions of Whole Blood or Red Blood Cells in Anemias"**
HOWARD L. ALT, Northwestern University Medical School, Chicago
2:55—**"Plasma Storage and Homologous Serum Jaundice"**
GARRETT ALLEN, University of Chicago Medical School, Chicago
3:05—**"Cost Analysis of a Blood Bank"**
H. A. GRIMM, Grant Hospital, Chicago
3:15—**"Gamma Globulin and Poliomyelitis"**
SIDNEY LEVINSON, Michael Reese Research Foundation, Chicago
To be discussed by: H. J. Shaughnessy, Ph.D., Illinois Department of Public Health
3:30 - 4:30—Question and Answer Period
Everyone should bring his questions concerning blood banking and transfusions.
4:30 - 5:00—Business meeting

●

The Physicians' Association of the Department of Public Welfare

President **R. C. Hubbard, Elgin**
Secretary-Treasurer **A. W. Glinert, Chicago State**
1st Vice President Heinz Goldschmidt, Peoria
2nd Vice President ... **M. R. Daple, Kankakee**
Program Chairman . **I. Spinka, Chicago State**

TUESDAY AFTERNOON, MAY 19, 1953

Parlor "M"

2:00—**"Teaching Psychiatry in a Medical Curriculum"**
WERNER TUTEUR, Elgin State Hospital, Elgin
"Methodological Problems in Establishing a Research Ward for Schizophrenia"
NATHANIAL S. APTER,
THEODORE TAUSIG, Manteno State Hospital, Manteno
"Changes in Brain Metabolism from Birth to Old Age in Animals and in Humans"
HAROLD E. HIMWICH, Galesburg State Research Hospital, Galesburg
"The 'Presenile' Psychoses?"
HERMAN JOSEPHY, Chicago State Hospital, Chicago
"Recent Advances in Studies of Virus Infections of the Nervous System"
HERMAN MASON, Ph.D., Illinois State Psychopathic Institute, Chicago

Section on Radiology

Chairman**Jerome M. Brosnan, Chicago**
Secretary**George Irwin, Jr., Bloomington**

TUESDAY AFTERNOON, MAY 19, 1953

Emerald Room — # 104

3:30 p. m. The guest moderator for the Section on Radiology will be Dr. John R. Hodgson of Rochester, Minnesota.
A film reading session will be held and all physicians who are interested will be most welcome.
Dr. Hodgson will speak before the General Assembly on Thursday afternoon.
Business Meeting—Election of Officers for 1954.

●

Section on Preventive Medicine and Public Health

Chairman**Charles F. Sutton, Springfield**
Secretary**Leroy L. Fatherree, Joliet**

The Section on Preventive Medicine and Public Health will have a luncheon at 12:00 noon on Tuesday, May 19, in the Gold Room (Room # 114) on the First Floor of the Hotel Sherman.

TUESDAY AFTERNOON, MAY 19, 1953

The Gold Room - # 114

2:00—**"Changes in the Rules and Regulations for the Control of Communicable Diseases"**
NORMAN J. ROSE, Chief, Bureau of Epidemiology, Illinois Department of Public Health, Springfield
Questions and Discussion
2:50—RECESS to view exhibits
3:20—**"Current Status of Gamma Globulin and Vaccines as Immunizing Agents for Poliomyelitis"**
HARRY F. DOWLING, Professor of Medicine and Head of Department of Medicine, University of Illinois College of Medicine, Chicago
Questions and Discussion
4:00—**"The Case Against Tracheotomy in Bulbar Poliomyelitis"**
FELIX A. TORNABENE, Health Officer, Northeastern Region, Illinois Department of Public Health, Aurora
Questions and Discussion
4:30—Business Meeting

Section on Obstetrics and Gynecology

Chairman**Hubert L. Allen, Alton**
Secretary **James P. FitzGibbons, Chicago**

TUESDAY AFTERNOON, MAY 19, 1953

Parlor "L"

1:30—**"Postpartum Anemia"**
JOHN R. WOLFF, Assistant Professor, Obstetrics and Gynecology, University of Illinois College of Medicine
MARVIN A. ROSNER, Clinical Assistant, University of Illinois College of Medicine, Chicago
1:50—**"Vaginal Plastic Operations at Time of Delivery"**
NEWTON DUPUY, Obstetrician-in-Chief, Physicians and Surgeons Clinic, Quincy
2:10—RECESS to view exhibits
2:40—**"Parturition After Operations on the Cervix"**
CHARLES D. KRAUSE, Assistant Professor, Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago
GEORGE P. VLASIS, Clincial Assistant, University of Illinois College of Medicine, Chicago

SYMPOSIUM - ELECTIVE INDUCTION OF LABOR

3:00—**ROBERT N. GRIER,** Assistant Professor, Obstetrics and Gynecology, Northwestern University Medical School, Chicago
3:15—**WILLARD C. SCRIVNER,** Assistant Professor, Obstetrics and Gynecology, Washington University School of Medicine, East St. Louis
3:30 **EDWIN J. DECOSTA,** Assistant Professor, Obstetrics and Gynecology, Northwestern University Medical School, Chicago
3:45—**JAMES E. FITZGERALD,** Professor, Obstetrics and Gynecology, Northwestern University Medical School, Chicago
4:00—Written QUESTIONS AND ANSWERS

●

WOMEN PHYSICIANS' BREAKFAST

WEDNESDAY MORNING, MAY 20, 1953

The Gold Room - # 114

8:00 a. m. On Wednesday morning the

women physicians registered at the 1953 annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

Norma Lee Browning, reporter from the Chicago Daily Tribune, will be the speaker. Dr. Helen Heinen of Chicago is the Chairman for the meeting this year, and she plans to contact all women physicians to make reservations. If you desire to attend, may we suggest that you drop a note to: Helen Heinen, M.D., 800 West 78th Street, Chicago 20, Illinois.

"HOSPITALITY ROOM"

The women physicians will have a hospitality room again this year for the four days of the meeting. Hostesses will serve coffee, and all women physicians are welcome to drop in at any time. We will have the suite number posted at the registration desk.

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Section on Dermatology

Chairman Malcolm Spencer, Decatur

WEDNESDAY MORNING, MAY 20, 1953

Parlor "L"

Papers—10 minutes
Discussions—5 minutes

9:00—Introductory Remarks by Temporary Chairman: Malcolm C. Spencer, Danville

"History of Dermatology in Illinois"
SAMUEL J. ZAKON, Chicago
Discussant: **JOHN M. McCUSKEY,** Peoria

"Acne—Some Recent Concepts of Etiology and Management"
J. WILLIAM DIDCOCT, Urbana
Discussant: **LOUIS RUBIN,** Rockford

"Re-evaluation of Hemangiomas"
ALBERT H. SLEPYAN, Highland Park
Discussant: **THEODORE CORNBLEET,** Chicago

"The Psoriasis Problem"
HANS M. BULEY, The Christie Clinic, Champaign
Discussant: **WILTON ROBIN,** Chicago

"Non-Specific Cutaneous Manifestations of the Lymphomas and Internal Cancer"
SAMUEL M. BLUEFARB, Chicago
Discussant: **JULIUS GINSBERG,** Chicago

"The Effect of Selenium on the Understanding and Management of Seborrhea"
WILLIAM M. SLINGER, Rockford
Discussant: **HILLIARD M. SHAIR,** Quincy

"Resistant Superficial Fungus Infections - Clinical Evaluation and Management"
ALLEN L. LORINCZ, Chicago
Discussant: **ISAAC M. FELSHER,** Chicago

"Recent Dermatologic Hazards in Industry"
LEONARD F. WEBER, Chicago
Discussant: **FREDERICK SZYMANSKI,** Chicago

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Section on Pediatrics

Chairman Harry H. Boyle, Chicago
Secretary James B. Gillespie, Urbana

WEDNESDAY MORNING, MAY 20, 1953

Louis XVI Room

SYMPOSIUM

"The Uses and Abuses of Chemotherapeutic and Antibiotic Agents for Infections in Children"

9:00—**"Uncomplicated Upper Respiratory Infections in Children and the Promiscuous Use of Chemotherapeutic Agents"**
L. MARTIN HARDY, Children's Memorial Hospital, Chicago

9:30—**"Review of Literature and a Preliminary Report on a Controlled Study in the Uses of Chemotherapeutic and Antibiotic Agents in Uncomplicated Upper Respiratory Infections in Children"**
HOWARD S. TRAISMAN, Children's Memorial Hospital, Chicago

9:50—**"Chemotherapeutic and Antibiotic Agents in the Treatment of Complications of Upper Respiratory Infections in Children"**
PAUL P. PIERCE, Alton

10:10—RECESS to view exhibits

10:40—**"Chemotherapeutic and Antibiotic Agents in the Treatment of Meningitides and Gastro-Intestinal Infections in Children"**
Walter M. Whitaker, Quincy

11:00—**"The Failure of Antibiotic and Chemotherapeutic Agents Because of Neglected Basic Principles in the Treatment of Otolaryngologic Infections"**
JAMES S. WALKER, Carle Memorial Hospital, Urbana

11:20—**"Chemotherapeutic and Antibiotic Agents in the Treatment of Genito-Urinary Infections in Children"**
DON E. MURRAY, St. Luke's Hospital, Chicago

11:40—Questions and Discussion
Business Meeting. Election of Officers for 1954.

Illinois Chapter of the American Academy of Pediatrics

WEDNESDAY NOON, MAY 20, 1953

Louis XVI Room

The Illinois Chapter, American Academy of Pediatrics will have its annual meeting in conjunction with the annual meeting of the Illinois State Medical Society on Wednesday, May 20, 1953, immediately following the scientific meeting of the Section on Pediatrics.

It will be a luncheon meeting, and according to present plans, will be held in the same room as the morning scientific session, thereby facilitating a shift from an intellectual feast to a gastronomic one with a minimum of effort.

As in the past, this luncheon will be an open meeting. All physicians and their wives are cordially invited to attend. All that is required is an interest in pediatrics and a ticket, which may be purchased for $4.00 at the registration desk.

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Section on Allergy

Chairman Harry L. Huber, Chicago
Secretary Morris A. Kaplan, Chicago

WEDNESDAY MORNING, MAY 20, 1953

Parlor "M"

9:00—**"The Role of the Physician in the Psychosomatic Problems of Allergy"**
BEN Z. RAPPAPORT, Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

9:20—**"Diagnostic Methods"**
MORRIS A. KAPLAN, Assistant Professor of Medicine, Chicago Medical School, Chicago

9:40—**"Allergic Rhinitis"**
ELLIS A. CANTERBURY, Staff, St. Francis Hospital, Peoria

10:00—**"Bronchial Asthma"**
LEON UNGER, Attending Physician, Cook County and Wesley Memorial Hospitals, Chicago

10:20—RECESS to view exhibits

10:40—**"Differential Diagnosis of Pulmonary Conditions"**
M. R. LICHTENSTEIN, Acting Medical Director, Municipal Tuberculosis Sanatorium, Chicago
LEROY H. BERARD, Assistant Chief of Medical Services, Municipal Tuberculosis Sanatorium, Chicago

11:00—**"The Allergic Cripple"**
TOWNSEND B. FRIEDMAN, Chairman, Department of Allergy, Children's Memorial Hospital, Chicago

11:20—**"Dermatology in Allergy"**
JAMES R. WEBSTER, Professor of Dermatology, Northwestern University Medical School, Chicago.

Business Meeting. Election of Officers for 1954.

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Section on Surgery

Chairman J. C. Thomas Rogers, Urbana
Secretary Arkell M. Vaughn, Chicago

WEDNESDAY MORNING, MAY 20, 1953

Parlor "O"

9:00—**"Obscure Gastro-Intestinal Bleeding"**
LORIN W. WHITTAKER, Peoria

9:15—**"Carcinoma of the Thyroid and Its Relation to Nodular Goiter"**
LEO ZIMMERMAN, Professor of Surgery, and Co-Chairman, Department of Surgery, Chicago Medical School, Chicago
DAVID H. WAGNER, Chicago

9:30—**"Surgery of the Aged"**
ARMAND D. ALBRECHT, Champaign

9:45—**"Anatomic Dangers in Gallbladder Surgery"**
MANUEL E. LICHTENSTEIN, Professor of Surgery, Cook County Graduate School of Medicine; Associate Professor of Surgery, Northwestern University Medical School, Chicago

10:00—**"Acute Pancreatitis"**
CHARLES E. BALDRE, JR., Instructor in Surgery, St. Louis University Medical School, Belleville

10:15—**"Benign Lesions of the Small Intestines"**
HARRY A. OBERHELMAN, Professor and Chairman, Department of Surgery Stritch School of Medicine of Loyola University, Chicago

10:30—**"Surgical Lesions of the Breast"**
GORDON F. MOORE, Alton

10:45—**"Differential Diagnosis of X-Ray Shadows in the Chest"**
WILLIAM M. LEES, Chief Surgeon, Municipal Tuberculosis Sanitarium, Clinical Assistant Professor of Surgery, Stritch School of Medicine, Loyola University, Chicago.

Business Meeting. Election of Officers for 1954.

GENERAL ASSEMBLY

WEDNESDAY AFTERNOON, MAY 20, 1953
Ballroom

Presiding Harry H. Boyle, Chicago
Assisting Earl H. Merz, Chicago

1:20—Opening of the General Assembly
LEO P. A. SWEENEY, President, Illinois State Medical Society, Chicago

1:30—**"The Treatment of Convulsions in Childhood"**
M. G. PETERMAN, Milwaukee, Wisconsin Head of Department of Pediatrics, Milwaukee County General Hospital

2:00—PRESIDENT'S ADDRESS "This I Believe"
LEO P. A. SWEENEY, Chicago

2:30—**"The Present Status of Vagotomy"**
LESTER R. DRAGSTEDT, Professor and Chairman, Department of Surgery, University of Chicago

2:50—RECESS to view exhibits

Presiding Hugh A. Flack, Chicago
Assisting A. R. K. Matthews, Rockford

3:20—**"The New in Dermatology"**
HERBERT RATTNER, Professor and Chairman, Department of Dermatology, Northwestern University Medical School, Chicago

3:40—**"Management of Cardiac Patients in Relation to Surgery, Anesthesia, and Obstetrics"**
A. CARLTON ERNSTENE, Chief of Staff, Division of Medicine, Cleveland Clinic, Cleveland, Ohio

4:10—**"Ocular Manifestations of Constitutional Disease"**
HAROLD F. FALLS, Professor of Ophthalmology, University of Michigan, Ann Arbor, Michigan

4:40—**"Diagnosis and Treatment of Pigmented Moles and Melanomas"**
S. WILLIAM BECKER, Clinical Professor of Dermatology, University of Chicago, Chicago

THURSDAY MORNING, MAY 21, 1953
Ballroom

Presiding Arkell M. Vaughn, Chicago
Assisting Hubert L. Allen, Alton

9:00—**"The Physiological Basis for the Use of ACTH and Cortisone in Allergic States"**
RACHMIEL LEVINE, Chairman, Department of Medicine, Michael Reese Hospital, Chicago

9:20—**"Complications of Labor"**
JOHN H. RANDALL, Professor of Obstetrics and Gynecology, and Head of the Department, University of Iowa School of Medicine, Iowa City, Iowa

9:50—ORATION IN SURGERY: **"The Diagnosis of Occult Ectopic Pregnancy"**
CHARLES S. STEVENSON, Department of Obstetrics and Gynecology, Wayne University School of Medicine, Detroit, Michigan

10:35—RECESS to view exhibits

Presiding Franklin J. Moore, Chicago
Assisting Morris A. Kaplan, Chicago

11:00—**"Do You Need to Know About Allergy?"**
J. HARVEY BLACK, Formerly Professor of Clinical Medicine, Southwestern Medical School of the University of Texas, Dallas, Texas

11:30—**"Current Trends in Viral Disease"**
JOHN P. WYATT, Professor of Pathology, St. Louis University School of Medicine, St. Louis, Missouri

THURSDAY AFTERNOON, MAY 21, 1953
Ballroom

Presiding Charles F. Sutton, Springfield
Assisting Jerome M. Brosnan, Chicago

1:30—**"The Management of Acute Intestinal Obstruction"**
B. MARDEN BLACK, Associate Professor of Surgery, Mayo Foundation, Rochester, Minnesota

2:00—**"Looking Ahead in Public Health"**
ROLAND R. CROSS, Director, Illinois Department of Public Health, Springfield

2:20—ORATION IN MEDICINE "The Impact of Modern Antibacterial Therapy on the Social and Economic Aspects of the Practice of Medicine".
PERRIN H. LONG, Professor of Medicine, College of Medicine State University of New York, at New York City.

3:05—RECESS to view exhibits

Presiding James B. Gillespie, Urbana
Assisting Malcolm Spencer, Danville

3:30—**"Coroner Versus Medical Examiner"**
ALAN R. MORITZ, Professor of Pathology and Director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio

4:00—**"Dermatologic Emergencies Seen in General Practice"**
PAUL A. O'LEARY, Professor of Dermatology and Syphilology, University of Minnesota

4:30—**"What Can the Radiologist Contribute to the Diagnosis of Gastro-intestinal Disease in Children?"**
JOHN R. HODGSON, Mayo Clinic, Rochester, Minnesota

FRIDAY MORNING, MAY 22, 1953
Ballroom

Presiding Walter H. Baer, Springfield
Assisting William F. Hubble, Decatur

9:00—**"Recent Advances in Treatment of Sinus Disease"**
O. E. VANALYEA, Clinical Professor, Otolaryngology, University of Illinois College of Medicine, Chicago

9:20—**"Contribution from Psychiatry to the General Practice of Medicine"**
LEO H. BARTEMEIER, Chairman of the Committee on Mental Health of the American Medical Association; Associate Professor of Psychiatry, Wayne University School of Medicine, Detroit, Michigan

9:50—**"Coronary Heart Disease"**
V. THOMAS AUSTIN, President, Illinois Heart Association, Senior Medical Consultant and Cardiologist, Carle Hospital, Urbana

10:10—RECESS to view exhibits

SYMPOSIUM
Post-Operative Care of the Patient
Presiding J. C. Thomas Rogers
Moderator

10:40—**"Surgical Aspects on Post-Operative Care of the Patient"**
WARREN H. COLE, Professor, Chairman, Department of Surgery, University of Illinois College of Medicine, Chicago

10:55—**"Medical Aspects on Post-Operative Care of the Patient"**
SMITH FREEMAN, Northwestern University Medical School, Chicago

11:10—**"Radiological Aspects on Post-Operative Care of the Patient"**
JOHN H. GILMORE, Roentgenologist, Illinois Masonic Hospital, Chicago

11:25—**"Anesthetic Aspects on Post-Operative Care of the Patient"**
LAURENCE RUTTLE, Joliet

11:40—Question and Answer Period.

FRIDAY AFTERNOON, MAY 22, 1953
Ballroom

Presiding Wright Adams, Chicago

1:30—**"Acid Base Balance During Anesthesia"**
EMANUEL M. PAPPER, Director of Anesthesia Service, Presbyterian Hospital, New York City

SYMPOSIUM
"Neonatal Death — Its Prevention"

2:00—**"Intra-Uterine Accidents and Complications"**
FREDERICK H. FALLS, Professor and Head of the Department of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago

2:15—**"Effects of Anesthesia"**
PAUL SEARLES, Director, Department of Anesthesia, St. Luke's Hospital, Chicago

2:30—**"Factors in Infant Care"**
HEYWORTH N. SANFORD, Professor of Pediatrics, Acting Head of the Department of Pediatrics, University of Illinois College of Medicine, Chicago

2:45—**"Pathology of Neonatal Death"**
JOSEPH BOGGS, Director of Laboratories, Children's Memorial Hospital, Chicago

3:00—Question and Answer Period

3:15—Adjournment.

MEETINGS OF THE HOUSE OF DELEGATES

The First Meeting of the House of Delegates will be held on Tuesday afternoon, May 19, 1953, at 3:00 o'clock in the Louis XVI Room. The meeting will be called to order by the President for the:

(1) Appointment of Reference Committees
(2) Reports of Officers, Councilors, Committees,
(3) Introduction of Resolutions,

and for the transaction of other business which may come before the House.

At this meeting, all matters are referred to the various Reference Committees which will meet on Wednesday morning and afternoon. The members of the Reference Committees will be announced and the place and time of the meetings will be posted. Any physician attending the annual meeting is privileged to appear before these committees to discuss any matter under consideration. Following the open hearings, the Committees will go into executive session to prepare their reports to the House. Reports will be made at the second and third meetings of the House as follows:

SECOND MEETING OF THE HOUSE OF DELEGATES will be held on Thursday afternoon, May 21, 1953, in Parlors L, M, and O, on the Mezzanine Floor at 3:00 o'clock, to hear those reports which are ready to be presented.

THE THIRD MEETING OF THE HOUSE OF DELEGATES will be held Friday morning May 22, 1953, at 8:30 a.m. in Parlors L, M, and O on the Mezzanine Floor to hear those reports remaining to be presented, and for the election of officers, Councilors, Committees, Delegates and Alternates to the American Medical Association, and to transact any other business to come before the House.

At the close of this last meeting, Dr. Willis I. Lewis of Herrin will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, Dr. Leo P. A. Sweeney, of Chicago.

VARIOUS ALUMNI MEETINGS

During the annual meeting of the Illinois State Medical Society, the alumni associations of various schools and organizations, plan to meet.

UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE

The University of Illinois College of Medicine Alumni Association will hold an annual banquet at the Bismarck Hotel, Chicago, the evening of Thursday, May 21, 1953. Cocktails at 6:00 p.m. with dinner served at 7:00 o'clock.

Reservations are to be mailed to Dr. Michael H. Streicher, 1853 West Polk Street, Chicago 12, Illinois. The cost per plate is $7.50. Informal.

PHI CHI FRATERNITY

The Phi Chi Alumni will have a luncheon meeting at the Hotel Sherman, Thursday noon, May 21, 1953, in the Emerald Room — Room 104 — at 12:00 o'clock. Arrangements are being made by Dr. Arkell M. Vaughn, 30 North Michigan Ave., Chicago, and by Dr. Jacob E. Reisch, 500 South 5th Street, Springfield. Reservations may be made through either of these men, and tickets will be on sale in the lobby of the Hotel during the meeting.

LOYOLA UNIVERSITY MEDICAL ALUMNI
Dr. E. J. McCormick—President Elect of the A.M.A.—Honored Guest

The Medical Alumni of Loyola University will have its annual dinner during the annual meeting of the Illinois State Medical Society on Thursday evening, May 21, at 7:00 o'clock, in the Louis XIV Room. The Rev. Michael I. English will be in charge of the arrangements.

The special theme of the meeting will give recognition to the silver anniversary class of 1928.

Honor guest at the dinner will be EDWARD J. McCORMICK, M.D., of Toledo, Ohio, President Elect of the American Medical Association, who will fly to Chicago to attend the dinner.

Tickets will be on sale at the special ticket table in the lobby.

SOCIAL FUNCTIONS

Throughout the annual meeting various social functions will be held. On Tuesday evening, May 19, 1953, the annual SECRETARIES' CONFERENCE is scheduled in the Crystal Room at 6:00 p.m. This meeting is to be over early this year so that the men can attend the TWENTY FIFTH ANNIVERSARY BALL of the Woman's Auxiliary to be held in the Ballroom that evening. A buffet supper will be served there from 7:30 to 10:00 p.m., and those physicians who attend the Secretaries' Conference will be able to purchase a "stub" ticket for the evening entertainment only. The women have planned their silver anniversary carefully, and undoubtedly, this evening will be the highlight of the 1953 meeting.

On Wednesday noon, May 20, 1953, the Fifty Year Club luncheon will be held at 12:00 o'clock in the Crystal Room. Dr. Andy Hall, Chairman of the FIFTY YEAR CLUB since its founding in 1937, will preside again this year at the annual complimentary luncheon honoring the members of his club. All physicians who have been in the practice of medicine for fifty years or more will be the guests of the Illinois State Medical Society at one of the most popular social affairs taking place during the annual session of the Society. All members of the Fifty Year club are invited to attend, and tickets for the luncheon may be secured at the registration table.

THE ANNUAL DINNER

On Wednesday evening, May 20, 1953, the annual dinner honoring the retiring President, Dr. Leo P. A. Sweeney of Chicago, will be held. The immediate past president, Dr. C. Paul White of Kewanee, will be the toastmaster. The main address of the evening will be given immediately after the dinner. In closing the program, the Past Presidents and guests of honor will be introduced, and Dr. Sweeney will be presented with his President's Certificate by the Chairman of the Council, Dr. F. Lee Stone of Chicago. The dinner music will be furnished by The Irving Margraff Ensemble.

PUBLIC RELATIONS DINNER

This year the Society will be host to county and branch society Public Relations Chairmen at a dinner to be held on Thursday evening, May 21, 1953 — in the Crystal Room on the First Floor of the Hotel Sherman.

The Council of the Illinois State Medical Society approved this plan for a new meeting and Mr. James C. Leary, Director of Public Relations for the State Society, was instructed to prepare informative material for the evening program.

Each county and branch society in Illinois should have some member interested in public relations who could attend his dinner meeting and report back to his fellow members in detail what the plans are for coming work in this important field.

HOSPITALITY HOUR

The dinners held on Thursday evening (The Public Relations Dinner outlined above; the University of Illinois Alumni, the Stritch School of Medicine of Loyola, etc.) must all adjourn by 9:00 o'clock in order that the physicians attending the annual meeting, may take part in the annual Fellowship Hour scheduled in the Bal Tabarin.

All the technical exhibitors will be invited to join the physicians again this year; the local committee will be delegated the responsibility of extending the invitation of the Society to the commercial houses to join in making this evening one of fun and entertainment.

Your Society is the host for the evening. Come and get acquainted.

SCIENTIFIC EXHIBITS

Booth 1

Title: "Persistence of Symptoms following Cholecystectomy Etiologic Factors and Preventive Measures"

Exhibitor: Manuel E. Lichtenstein and Anthony J. Nicosia

Institution: Cook County Graduate School of Medicine and Northwestern University Medical School

Description: The exhibit is made up of illustrations and specimens of the extrahepatic biliary passages with their accompanying vessels, and posters presenting information valuable in reducing the incidence of poor results following gall bladder surgery. Unfavorable results following cholecystectomy may be classified in five groups: (1) incomplete diagnosis, (2) incomplete surgery, (3) accidents involving the extrahepatic biliary system, (4) post-operative complications, (5) non-surgical gall bladder disease.

Booth 2

Title: "Pathology of the Facial Bones"

Exhibitor: Casper M. Epsteen, Chicago, Illinois

Description: A series of about 30 photoroentgenograms and drawings (with descriptions of each), about 50 5x7 colored transparencies, and about 100 black and white slides depicting various pathological lesions of the facial bones.

Booth 3

Title: "Every Doctor's Office a Cancer Detection Center"

Exhibitor: Eloise Parsons, Caesar Portes, Marie Ortmayer, Evangeline Stenhouse, Elizabeth A. McGrew, Marion F. Magalotti

Institution: Cancer Prevention Center of Chicago, Inc.

Description: The majority of cancers are so located that they may be detected by a thorough physical examination. About 40,000 apparently healthy people examined at the Cancer Prevention Center of Chicago. Statistics to be given.

Booth 4

Title: "Casework at Work"

Exhibitor: Chicago Department of Welfare

Description: Photographic — Rehabilitation — Physical Medicine

Booth 5

Title: "Carbon Dioxide Therapy of the Neurosis"

Exhibitor: A. I. Jackman, Committee on Carbon Dioxide Research

Description: Charts showing mechanisms of action, method of evaluating and statistics of CO_2 therapy of neurosis. Also equipment for administering their treatment. Reprints will be available of articles on CO_2 treatment.

Booth 6

Title: "Female Sterility"

Exhibitor: Frederick H. Falls and Charlotte S. Holt

Institution: University of Illinois, College of Medicine and Illinois Department of Public Health

Description: The exhibit will be comprised of drawings, lettered charts, sculptures, plastic carvings, microphotographs and x-rays demonstrating the important basic factors in the etiology, physiology, pathology, diagnosis and treatment of sterility problems as presented to the gynecologists.

Booth 7

Title: "Myomectomy as Related to Sterility"

Exhibitor: Helen L. Button and Edward G. Warnick

Institution: Cook County Graduate School of Medicine, Cook County Hospital, Women's and Children's Hospital, Stritch School of Medicine, Loyola University

Description: "Since cure without deformity or loss of function must ever be surgery's highest ideal, the general proposition that Myomectomy is a greater surgical achievement than Hysterectomy is incontestable." Reprints of article in Am. Med. Women's Journal, Victor Bonney, "Myomectomy as Related to Sterility." The exhibit consists of a panel of drawings illustrating the Bonney technique of myomectomy, and demonstration of the Bonney clamp. Also, a series of hysterosalpingograms, and gross specimens with histopathologic sections of fibroid uteri. The diagnosis and treatment of patients with fibroids in the childbearing age is discussed.

Booth 8

Title: "Office Procedures in Proctology"

Exhibitor: Manuel G. Spiesman and Louis Malow

Description: The exhibit depicts the practical office procedures for the diagnosis of lesions of the rectum and lower Sigmoid.

Booth 9

Title: "The Three Dimensional Architecture of the Human Adrenal Cortex"

Exhibitor: Hans Elias, John E. Pauly and Hans Popper

Institution: Department of Anatomy, the Chicago Medical School; The Hektoen Institute for Medical Research and the Department of Pathology, Cook County Hospital

Description: Stereograms, photomicrographs and models will depict the structure of the Adrenal Gland.

Booth 10

Title: "Relationship of the Right Hepatic and Cystic Arteries to the Extrahepatic System as seen in the Operating Room"

Exhibitor: J. Major Greene and Earle I. Greene

Institution: Cook County Hospital, Chicago Medical School, Grant Hospital, Mt. Sinai Hospital

Description: Wax models diagramatically illustrating the various locations of the right hepatic and cystic arteries in relationship to the hepatic, common and cystic ducts. Knowledge of these abnormal locations will prevent injury to the right hepatic artery and extrahepatic system during surgery.

Booth 11

Title: "Aeroallergens of Illinois"

Exhibitor: Oren C. Curham and Ralph F. Voigt

Institution: Abbott Laboratories and University of Illinois College of Pharmacy

Description: Pollen and fungus spore surveys have been carried on in no less than 13 Illinois cities and towns over a period of 28 years. The condensed data secured in these studies will be shown in graphic and tabular form and by means of maps and photographs. Aerobiologic methods will be demonstrated, and the 1953 revision of the North American Ragweed index will be available in pamphlet form.

Booth 12

Title: "Contact Roentgen Radiation of Accessible Neoplasms"

Exhibitor: Eugene F. Lutterbeck, Irvin F. Hummon, Morris T. Friedell

Institution: Cook County Hospital, Department of Radiation Therapy and Surgery, Stritch School of Medicine

Description: The exhibit demonstrates the use of Contact Roentgen Radiation for the treatment of accessible or surgically exposed neoplasms. Charts and photographs will explain technical data, the characteristics of the Phillips Contact Tube and the technique for the treatment of large areas. To demonstrate the use of this method, colored photographs of illustrative cases are shown. (1) Accessible superficial neoplasms, single and multiple, small or large. (2) Accessible cavity lesions; oral cavity, vagina and rectum. (3) Surgically exposed lesions, such as Carcinoma of the larynx. The immediate and direct radiation of the tumor base following surgical removal of the tumor bulk, such as Carcinoma of the breast, neurofibrosarcoma.

Booth 13

Title: "Industrial Health — Small Plants"

Exhibitor: American Medical Association

Description: The exhibit portrays the need for participation by general practitioners in the health program of small industrial plants (under 500 employees). Other phases of the exhibit include what can be done, the cost, essentials for an industrial health program in small industry, and how to place a plan in operation.

Booth 14

Title: "Erythrocin"

Exhibitor: L. E. Josselyn, George H. Berryman, and John C. Sylvester

Institution: Abbott Laboratories

Description: The chemistry, pharmacology, bacteriology, and clinical phases of Erythrocin (erythromycin, Abbott) will be described and illustrated by means of graphs, charts, photographs, and drawings. The antibacterial spectrum, including range of inhibitory concentrations, will be presented along with illustrations of the development of resistance and possibly antagonism and synergism. We also plan to present comparisons of relative potencies between Erythrocin and certain other common antibiotics. Summaries of clinical reports and tabulations of types of cases will be presented to

cover the range of usefulness of this antibiotic.

Booth 15

Title: "Superficial Fungous Infections of the Skin, Nails and Hairs"

Exhibitor: I. Myron Felsher, and A. Goldberg

Institution: Northwestern University Medical School

Description: Sixty-three excellent colorchromes 5x7 of the common superficial mycoses and their d.d.—concise outlines for the correct diagnosis and treatment—common errors—gross and microscopic demonstration of fungal elements and cultures.

Booth 16

Title: "Continually Recorded Oxygen Concentrations in Oxygen Tents"

Exhibitor: Albert H. Andrews, Jr.

Institution: St. Luke's Hospital

Description: The effectiveness of oxygen tent therapy is the oxygen concentration. Exhibit consists of the following: (1) Methods: Description of apparatus, records, and calibration of instrument. (2) Routine recordings of oxygen tent concentration. (3) Records demonstrating effect of common errors in oxygen tent therapy. (4) Records demonstrating effects of different techniques on oxygen concentrations. (5) Summary showing the best techniques of oxygen tent therapy based on the presented records.

Booth 17

Title: "Keloids Treated with Hyaluronidase"

Exhibitor: Theodore Cornbleet and Hubert Catchpole

Institution: University of Illinois, College of Medicine

Description: An exposition of the method for treating keloids with hyaluronidase together with histological and clinical illustrations of results. The theoretical background on connective tissue ground substance apropos to the problem is discussed.

Booth 18

Title: "Thyroid tumors"

Exhibitor: Leo M. Zimmerman and David H. Wagner

Institution: Chicago Medical School and Michael Reese Hospital

Description: Subject matter of the exhibit includes an 18 year study of all surgical specimens of the thyroid gland at Michael Reese Hospital with particular reference to the incidence of thyroid nodules, adenomas and carcinomas. Their respective relationship is emphasized. In addition these data are correlated with the death rate from carcinoma of the thyroid as shown by autopsy and vital statistics.

Booth 19

Title: "Acute Anuria"

Exhibitor: Samuel A. Levinson and Max Berg

Institution: University of Illinois, College of Medicine

Description: This exhibit summarizes first the important recent contributions on the pathogenesis and pathologic physiology of acute anuria including experimental work of the authors. Secondly, it presents the recent advances in the treatment of acute anuria based upon the correction of the pathologic physiology and clinical experience.

Booth 20

Title: "Prevention and Treatment of Rheumatic Fever"

Exhibitor: Chicago Heart Association

Description: This display is based on the recent release in the Journal of the American Medical Association by the Council on Rheumatic Fever and Congenital Heart Disease. The display will also outline the objectives of the Chicago and Illinois Heart Associations.

Booth 21

Title: "The Hospital Medical Audit"

Exhibitor: The Medical Staff of Grant Hospital, W. Hutchinson, Medical Director and H. A. Grimm, Chairman, Medical Records Committee

Institution: Grant Hospital of Chicago

Description: The exhibit outlines the mechanics by which a hospital staff can initiate the system of the medical audit. The composition of the committees needed for the staff organization are outlined. The advantages of the professional audit are emphasized.

Booth 22

Title: "A Gross Sectional Study of the Subcutaneous Layer of the Anterior and Lateral Trunk — photographically recorded."

Exhibitor: E. D. Congdon

Institution: Chicago Medical School, Department of Anatomy

Booth 23

Title: "Experimental Diabetes"

Exhibitor: Piero P. Foa, Jay A. Smith, Harriett R. Weinstein, Edward G. Nagid, Morton D. Glassman

Institution: Chicago Medical School, Department of Physiology and Pharmacology

Description: The exhibit consists of a series of charts describing changes in blood sugar concentration. The effects of insulin, epinephrine, the pancreatic hyperglycemic factor of the pancreas and the growth hormone of the anterior pituitary gland in normal and diabetic animals are described.

Booth 24

Title: "Food Allergy and Food Addiction"

Exhibitor: Theron G. Randolph, M.D.

Description: The ordinary conception of food allergy in which the ingestion of a specific food is followed by the prompt development of an observable clinical reaction is much more apt to occur to the infrequent ingestion of an allergenic food than to the cumulative ingestion of a common article of the diet. In the presence of a high degree of specific sensitivity to such common foods as corn, wheat, milk, eggs, potato, coffee and others, ingested in some form several times per day, an addictive type of allergic response often develops. This is characterized by an immediate post-ingestive "lift" or relative amelioration of the previously existing chronic level of symptomatology, and in turn, by a subsequent "letdown" or delayed recurrence of symptoms similar to withdrawal effects. Addictive food allergy of moderate degree accounts for the fact that most patients are not aware of the existence of clinical sensitivity to the common articles of the diet. In extreme instances, including at least certain cases of obesity and alcoholism, this relationship between the ingestion of food or drink and the immediate improvement of symptoms has been recognized and is expressed as a compulsive craving, respectively, for food or drink in general (usually including certain specific allergens) or for particular foods or drinks. This exhibit describes these radically different mechanisms of food allergy dependent upon the frequency of ingestion of specific allergens as well as differences in the symptomatology, methods of diagnosis and therapy of food allergy and food addiction. This exhibit is based on the published data listed as references which will form the final panel of the 25 charts employed in the presentation.

Booth 25

Title: "Obesity"

Exhibitor: P. V. Dilts

Institution: Springfield Clinic

Description: Twenty-two 13" x 17" placards illustrating enlarged type of article.

Booth 26

Title: "The Cost of Blood Transfusions"

Exhibitor: Harold A. Grimm, Coye C. Mason, and Dorothy Pinkham

Institution: Grant Hospital of Chicago

Description: The exhibit shows the cost of a blood transfusion 25 years ago as compared to current costs. The exhibit emphasizes the hidden costs which are ever present in the operation of a blood bank. This includes technician's salaries, blood bank equipment, expendable equipment, etc.

Booth 27

Title: "A Group Approach to Cerebral Palsy"

Exhibitor: A. W. Fleming, J. Coyle, J. Koczur

Institution: Mercy Hospital Cerebral Clinic, Stritch School of Medicine of Loyola University

Description: Benefits of combined approach to patient, community and medical school.

MOTION PICTURES

Time

9:00 a.m. (30 min.) "Dissection in Continuity for Carcinoma of the Head and Neck," Hans von Leden, Northwestern University Medical School.

9:31 a.m. (30 min.) "The Diagnosis of Poliomyelitis", National Foundation for Infantile Paralysis.

10:02 (22 min.) "Glaucoma: What the General Practitioner Should Know", National Society for Prevention of Blindness.

10:25 a.m. (30 min.) "Vertigo: Differential Diagnosis", M. M. Hipskind, Samuel Salinger, Stritch School of Medicine, Loyola University.

10:56 a.m. (22 min.) "Spontaneous Rupture of the Esophagus", S. A. Mackler, Cook County Hospital, Chicago.

11:19 a.m. (29 min.) "Some Aspects of Accessible Cancers — Skin", Sir Stanford Cade, Malcolm Donaldson, G. F. Stebbing, Ministry of Health, London.

Intermission for Lunch

1:15 p.m. (20 min.) "Gastroesophageal Resection for Carcinoma of Lower Esophagus", Charles B. Puestow, Veterans Administration Hospital, Hines, Illinois.

1:36 p.m. (38 min.) "Special Problems in the Management of Peptic Ulcer", Everett Keifer, Lahey Clinic.

2:15 p.m. (23 min.) "Direct Inguinal Hernia", Philip Thorek.

2:40 p.m. (20 min.) "Operative Cholangiography", Frederick Hicker and A. J. McAllister, Department of Surgery, University of Utah.

3:01 p.m. (26 min.) "Sciatic Pain and the Intervertebral Disc", Bureau of Medicine and Surgery, U.S. Navy.

3:27 p.m. (17 min.) "Pyloromyotomy for Infantile Pyloric Stenosis".

3:45 p.m. (20 min.) "Pneumonectomy", Evarts Graham, Barnes Hospital, St. Louis.

4:06 p.m. (24 min.) "Some Aspects of Accessible Cancers — Rectum", Sir Stanford Cade, Malcolm Donaldson, G. F. Stebbing, Ministry of Health, London.

4:30 p.m. (18 min.) "Enzyme Therapy with Varidase", Rutledge Howard, Lederle Laboratories Division, American Cyanamid Company.

TECHNICAL EXHIBITORS

ABBOTT LABORATORIES
Booth 104
A. S. ALOE COMPANY
Booth No. 62

Visit Booth No. 62 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches and advanced design all in new decorators' colors.

AMERICAN HOSPITAL SUPPLY CORPORATION
Booth No. 108

American Hospital Supply Corporation will exhibit Baxter Intravenous Solutions, including Travert, the new invert sugar solution providing twice the calories as dextrose in the same infusion time; Baxter blood transfusion and plasma equipment, together with the complete line of Baxter expendable accessories for the intravenous solutions and blood and plasma bottles.

THE ARMOUR LABORATORIES
Booth No. 9

ARNAR-STONE LABORATORIES, INC.
Booth No. 26

AYERST, McKENNA & HARRISON Limited
Booth No. 82

BABY DEVELOPMENT CLINIC
Booth No. 7

BAKER LABORATORIES, Inc.
Booth No. 107

BILHUBER-KNOLL CORP.
Booth No. 106

The written prescription bespeaks the physician's treatment of the patient. The medicinal chemicals of Bilhuber-Knoll Corp. merit your study and use in your daily practice.

Bromural — Sedative — Mild hypnotic
Dilaudid — Analgesic — Cough sedative
Metrazol — Analeptic — Tonic
Octin — Antispasmodic
Quadrinal — Antiasthmatic
Valoctin — Sedo-spasmolytic

These prescription chemicals will be on display at Booth No. 106.

BLUE CROSS PLAN FOR HOSPITAL CARE AND BLUE SHIELD MEDICAL-SURGICAL PLAN
Booths No. 34 and 35

BROWN & WILLIAMSON TOBACCO CORPORATION
Booths No. 36 and 66

VICEROY

The exclusive Filter Tip on VICEROY Cigarettes provides important protection to smokers. A demonstration and explanation of its unique advantages will be of interest to all.

KOOL

Mildly mentholated KOOL Cigarettes are particularly desirable for smokers with sensitive and irritated throats. Willie the Penguin has an attractive souvenir for all doctors who visit the KOOL booth.

CAMEL CIGARETTES
Booth No. 64 and 65

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

CHICAGO PHARMACAL COMPANY
Booth No. 98

The Chicago Pharmacal Company welcomes your visit to our booth, which features the following Chimedic products: URISED, for the treatment of cystitis, providing both antisepsis and sedation; TOLYPHY, improved spasmolytic tablet combining mephenesin, physostigmine, and atropine; BEXII-M, injectable containing 1000 micrograms Vitamin B12 per each cc. — as well as the new Chimedic catalog which affords a full description of one of the most complete lines in the pharmaceutical manufacturing industry.

CIBA PHARMACEUTICAL PRODUCTS, INC.
Booth No. 95

The Ciba exhibit will feature APRESOLINE, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology.

Representatives in attendance will be very glad to discuss and to provide literature on this and other Ciba products.

THE COCA-COLA COMPANY
Booth No. 48

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Co. of Chicago, Inc. and The Coca-Cola Company.

DANIELS SURGICAL & MEDICAL SUPPLIES
Booths No. 51 and 52

DAYLESS MANUFACTURING CO., INC.
Booths No. 38 and 39

DOAK PHARMACAL CO.
Booth No. 67

"FOR THE FINEST IN DERMATOLOGICAL THERAPY — THINK OF 'DOAK'." Doak Company is pleased to exhibit a line of nationally recognized dermatological preparations time honored for their therapeutic superiority. Our Professional Service Representatives will be happy to acquaint you with the merits of "Doak" preparations, and the indications for their use. Included among the several products on display will be:

Buro-Sol Powder—(Soluable Powder Aluminum Acetate "Doak")—Anti-phologistic and astringent wet application or compress.

Lotio Alsulfa "Doak"—highly dispersed colloidal sulfur lotion.

Tersus "Doak"—The original soapless detergent with a constant pH of 6.8. Excellent skin cleanser and shampoo. Indicated in soap allergy, eczema, acne, seborrheic dermatitis.

DOHO CHEMICAL CORPORATION
Booth No. 2

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation is also fea-

turing RECTALGAN, the liquid topical anesthesia, also Bactericidal and Fungicidal for control of secondary invaders, particularly recommended for treatment of mold infections (monilia) occurring after anti-biotic therapy; also for relief of pain and discomforture in hemorrhoids, pruritus and perineal suturing.

EISELE & COMPANY
Booth No. 97

Eisele & Company will display their regular line of clinical thermometers, hypodermic syringes, both the regular type and interchangeables — hypodermic needles, eco bandages, and specialty glassware.

ELI LILLY AND COMPANY
Booth No. 28 and 29

You are cordially invited to visit the Lilly exhibit located in space numbers 28 and 29. New antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly salesmen will welcome your questions about these and other recent therapeutic developments.

ENCYCLOPAEDIA BRITANNICA
Booth No. 61

H. G. FISCHER & CO.
Booth No. 73

See the new 75 milliampere "Spacesaver" in the H. G. Fischer & Co. booth. It is without parallel in the x-ray industry, with a double-focus tube in a self-contained, shock-proof tubehead. It has enough power to meet every radiographic requirement of general practice—the ideal machine for the doctor's own office. Without obligation see interesting demonstration of this radiographic-fluoroscopic examining table unit and of short wave diathermy units having Federal Communications Commission approval.

GENERAL ELECTRIC COMPANY
X-Ray Department
Booths No. 88 and 89

GENERAL FOODS CORPORATION
Booth No. 78

HANOVIA CHEMICAL & MFG. COMPANY
Booth No. 76

See our special diagnostic black light display, the new general body irradiation professional lamp, air-cooled orificial lamp, Sollux radiant heat lamp and the Germicidal lamp for the destruction of air-borne bacteria; outstanding in appearance and performance. Courteous representatives will be pleased to greet you.

H. J. HEINZ COMPANY
Booth No. 60

WHAT'S NEW AT THE HEINZ EXHIBIT?

1. Heinz Strained Orange Juice, Heinz Precooked Rice Cereal, Heinz Strained Banana Custard Pudding and Heinz Strained Cream of Tuna.
2. Literature for your patients:
 "Strained Foods for Your Baby's Diet"
 "Junior Foods for Older Babies"
 "Recipe Magic Using Heinz Strained and Junior Foods"
 "Facts About Foods"
3. For office use:
 "Baby Gift Folders"
 "Nutritional Data"
 "Nutritional Observatory"

KELEKET X-RAY CORPORATION
Booth No. 112

LANTEEN MEDICAL LABORATORIES, INC.
Booth No. 85

Lanteen Medical Laboratories, Inc., extend a cordial invitation to visit their booth No. 85. The well known line of Lanteen Gynecic Specialties will be available for discussion.

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Booth No. 72

You are cordially invited to visit our exhibit in Booth No. 72 where you will find representatives who are prepared to give you the latest information on Lederle Products.

J. B. LIPPINCOTT COMPANY
Booth No. 102

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. LORILLARD COMPANY
Booths No. 92 and 93

MASSACHUSETTS INDEMNITY INSURANCE COMPANY
Booths 49 and 50

Generally, we hope to bring to your Exhibition Hall, in a dignified manner, a booth which emphasizes quality. Our copy is kept to a minimum, stressing only the important features, to avoid creating a "carnival" appearance. The booth is done in a natural birch finish with a blue and silver color scheme.

It is our purpose to direct to the attention

of the physician and surgeon the unusual merits of non-cancellable and guaranteed renewable disability income insurance protection and what it will do for him as an individual.

MEAD JOHNSON & COMPANY
Booth No. 79

MEDCO PRODUCTS COMPANY
Booth No. 10

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

MEDICAL AIDS, INC.
Booth No. 100

Medical Aids, Inc., will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer bandage plus the Dalzoflex Elastic Adhesive bandage which are used in treating Leg Ulcers and Phlebitis. Elastic Stockings, and the Nulast Elastic Crepe bandage will also be displayed.

MEDICAL ARTS SUPPLY CO.
Booth No. 24

THE MEDICAL PROTECTIVE COMPANY
Booth No. 59

With an unparalleled record of bona fide protection for doctors in the field of professional liability insurance, to which it has exclusively dedicated its efforts, The Medical Protective Company invites your visit to Booth No. 59. Our experience of more than half a century in this one field assures you of authoritative information from our specially trained representatives on any question arising out of the doctor-patient relationship.

MILLER SURGICAL CO.
Booth No. 96

MILLER SURGICAL COMPANY, Chicago, Illinois (Booth 96) will exhibit Electrically Illuminated Gorsch and Miller Rectal Scopes, Rectal Snares, Smoke Ejectors, Coagulators, Miller Electro-Scalpel and Cautery, Headlites, Reflecting etc. Miller Ophthalmoscope, Otoscopes and complete line of Illuminated and Magnifying Surgical Diagnostic Units.

THE C. V. MOSBY COMPANY
Booth No. 1

M & R LABORATORIES, INC.
Booth No. 105

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

V. MUELLER & COMPANY
Booth No. 101

Standard and special instruments, from our own shops and from abroad, will be shown, as well as the complete line of UL approved Mueller aspirating and ether pumps, and selected office furniture.

THE NATIONAL DRUG COMPANY
Booth No. 80

NEPERA CHEMICAL CO., INC.
Booth No. 77

PARKE, DAVIS & COMPANY
Booth No. 58

CHAS. PFIZER & CO., INC.
Booth No. 94

Terramycin, newest of the broad-spectrum antibiotics forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

PHILIP MORRIS & CO. LTD., INC.
Booth No. 27

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

A. H. ROBINS COMPANY, INC.
Booth No. 99

Physicians attending the Illinois State Medical Society are extended a cordial invitation to visit the exhibit of the A. H. Robins Company, which is this year celebrating its 75th year of service to the medical profession.

Experienced representatives will be in attendance to welcome you and answer inquiries relative to Robins' prescription specialties.

J. B. ROERIG AND COMPANY
Booth No. 86

Members of the Illinois State Medical Society are cordially invited to visit the booth of J. B. Roerig and Company. Professional Service Representatives will be on hand to welcome all interested visitors.

SANBORN COMPANY
Booth No. 25

Sanborn instruments to be shown at Booth No. 25 will include the direct-writing Viso-Cardiette; the Metabulator, latest model metabolism tester; and the Electrophrenic Respirator.

Full data will also be available concerning the Sanborn Poly-Viso and Twin-Viso (multichannel biophysical research recorders), the Electromanometer (for pressure recordings), and other new Sanborn instruments for cardiac and other research, teaching, and diagnosis.

SANDOZ CHEMICAL WORKS, INC.
Booth No. 8

Physicians attending the Illinois State Medical Convention are cordially invited to visit the Sandoz Pharmaceuticals display which feature the following:

CAFERGOT—the first effective oral preparation for the treatment of migraine and related headache.

BELLERGAL a time-tested preparation for use in functional disorders.

HYDERGINE a new approach and new product for hypertension and peripheral vascular diseases.

A new handbook listing our products will be available and representatives in attendance will gladly answer any questions about these and other Sandoz products.

W. B. SAUNDERS COMPANY
Booth No. 111

Don't miss seeing the new 1953 Current Therapy at the Saunders Booth. It's the most useful book on treatment ever published!

Also on display will be such important new books as: Alexander's Treatment of Mental Disorder; Dunphy & Botsford's Examination of the Surgical Patient; Parsons & Ulfelder's Pelvic Surgery; Lewis' Practical Dermatology; Beckman's Pharmacology in Clinical Practice; and many, many others.

SCHERING CORPORATION
Booth No. 57

JULIUS SCHMID, INC.
Booth No. 71

Ramses Gynecological Products. Fully A.M.A. accepted, these products are promoted to physicians exclusively. First and foremost of all chemical contraceptives to contain carboxymethylcellulose, RAMSES Vaginal Jelly not only has the fastest spermicidal time recognized by the A.M.A. but occludes the cervix for as long as ten hours.

G. D. SEARLE & CO.
Booth No. 30

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestril, the new synthetic estrogen for menopausal symptoms; Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed.

SECURITY LABORATORIES
Booths No. 53 and 54

SHERMAN LABORATORIES
Booth No. 90

Sherman Laboratories Present
PROTAMIDE

A sterile colloidal solution of processed and denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis (post infection), herpes zoster, tabes dorsalis and chickenpox.

GERICAPS

A lipotropic formula containing choline and inositol, rutin and Vitamin C, A and B-Complex. A lipotropica with "plus" factors as an aid in diabetes, coronary artery disease, atherosclerosis and faulty fat metabolism.

SMITH, KLINE & FRENCH LABS.
Booth No. 6

We extend a cordial invitation to you to visit our booth where 'Dexedrine' **SPANSULES** will be featured. Each capsule contains more than 100 tiny pellets with varying disintegration times. The 'Dexedrine' (15 mg.) is released gradually, yet uniformly, over a SPAN of 8 to 10 hours. Thus, in weight reduction, one 'Dexedrine' **SPANSULE,** taken on arising, curbs appetite evenly and effectively throughout the day.

E. R. SQUIBB & SONS
Booth No. 31
THE STUART COMPANY
Booth No. 109
TATTLE TOES COMPANY
Booth No. 63
TRAVENOL LABORATORIES, INC.
Subsidiary of Baxter Laboratories, Inc.
Booth 3

Travenol Laboratories, Inc., welcome the opportunity to see you at this exhibit. Extensive laboratory and clinical studies have demonstrated the efficacy, reliability, and safety of Piromen which is a new therapeutic agent.

Piromen is a sterile, nonprotein, non-antigenic bacterial component in a colloidal dispersion for parenteral use. Piromen is a stimulant for the endocrine and reticulo-endothelial systems, proven of value in the treatment of certain skin disorders, eye disorders, and allergies.

THE UPJOHN COMPANY
Booth No. 103
U. S. VITAMIN CORPORATION
Booth No. 5

See the "Oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research Laboratories.

Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops-multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solution and now Vi-Aqua Syrup—aqueous multivitamins in candy-like syrup . . . for more rapid absorption, more certain utilization . . . no fish taste, odor, no allergens.

We cordially invite you to our booth for detailed literature and professional samples.

VARICK PHARMACAL COMPANY
Booth No. 32

WESTINGHOUSE ELECTRIC CORPORATION
Booth No. 56

WINTHROP-STEARNS INC.
Booth No. 4

F. E. YOUNG & COMPANY
Booth No. 87

F. E. Young & Company, Booth No. 87, will exhibit Young's Dilators, Sulf-A-Test, PSP Test Set and Young's Albumin Test.

Young's Dilators are used in the treatment and prevention of contracted anus, particularly following hemorrhoidectomy, as an aid in perineal dissection and in the repair following delivery.

Sulf-A-Test, Young's PSP Test Set and Young's Albumin Test will be demonstrated.

THE ZEMMER COMPANY
Booth No. 110

COMMITTEES

LOCAL COMMITTEES ON ARRANGEMENTS
1953 Annual Meeting
General Chairman: FRED H. MULLER, 8056 South Justine Street, Chicago 20
Vice-Chairman: MAURICE M. HOELTGEN, 9401 S. Winchester Ave., Chicago 20

ADVISORY COMMITTEE
F. Lee Stone, Chairman

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Willis I. Lewis	Percy E. Hopkins
G. Henry Mundt	Eugene T. McEnery
Hugh N. MacKechnie	Robert S. Berghoff
Julius H. Hess	Warren W. Furey
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Helen Heinen, Chairman
Alice Phillips, Vice Chairman

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Walter Dziuk	H. L. Wallin
H. Lewandowski	Charles Papik
George A. Kirby	William Saphir
Robert Mustell	O. W. Rest
Dale S. Raines	John E. Siedlinski

E. Allen Parsons

RECEPTION COMMITTEE FOR HOSPITALITY NIGHT

F. M. Nicholson, Chairman
G. L. Kaufmann, Vice Chairman

S. M. Goldberger	Frank F. Maple
G. Henry Mundt, Jr.	Robert Arens
George O'Brien	F. J. Hultgen
M. J. Kutza	Charles Pope
William Patejdl	Paul C. Weber
Walter Kittler	T. J. Caldarola
W. H. Palmer	David Slight
John Wall	George Barnett
W. W. Sittler	Joseph M. Ruda

ANNUAL DINNER COMMITTEE

H. CLOSE HESSELTINE, Chairman

George Andrew	James Majarakis
Victor Engleman	Charles Mrazek
George Rukstinat	Arnold U. Derman
M. M. Hipskin	Paul Vermeren
Williard O. Thompson	J. J. Mullen
Roy M. Hohman	Russell Barrett
B. K. Lazarski	Warren C. Blim
Samuel Zakon	Fred L. Glenn

PUBLICITY COMMITTEE

Theodore R. VanDellen, Chairman

John R. Wolff	Harry M. Hedge
Elmer McCarthy	Clarence Saelhof
Norris J. Heckel	

Mr. James C. Leary, Secretary

PROGRAM
of the
TWENTY-FIFTH ANNUAL MEETING
of the
WOMAN'S AUXILIARY
to the
ILLINOIS STATE MEDICAL SOCIETY
May 18, 19, 20, 1953
HOTEL SHERMAN
CHICAGO, ILLINOIS

A most cordial invitation is extended to all members of the Woman's Auxiliary to the Illinois State Medical Society, and to the wives and guests of physicians attending the convention of the Illinois State Medical Society, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at the Hotel Sherman. Tickets may be secured at the registration desk only. Please register early and obtain your badge and program.

REGISTRATION HOURS
Lobby Floor

Monday 12:00 Noon to 5:00 P.M.
Tuesday 8:30 A.M. to 5:00 P.M.

PRECONVENTION SCHEDULE
Monday, May 18

12:00 Noon to 5:00 P.M.—REGISTRATION—Lobby Floor, Hotel Sherman.

The members of the Hospitality Committee will welcome members and

guests of the Woman's Auxiliary.

1:00 P.M.—Preconvention Board Meeting. Room No. 113.

3:00 P.M.—Preconvention Conference of presidents, presidents-elect and guests. Gold Room No. 114.

7:00 P.M.—Conference Supper
Bal Taberin

8:30 A.M. to 5:00 P.M. Registration Lobby Floor, Hotel Sherman.

CONVENTION PROGRAM
Tuesday, May 19

8:30 A.M. to 5:00 P.M. Registration Lobby Floor, Hotel Sherman.

9.00 A.M.—Formal opening of the Twenty-fifth Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society
Mrs. Harlan English, President, presiding
Pledge to the Flag—Mrs. C. Paul White
Invocation—Rev. Charles Ray Goff, First Methodist Church, Chicago
Welcome — Mrs. H. Close Hesseltine, President, Woman's Auxiliary to the Chicago Medical Society
Response — Mrs. J. S. Lundholm, Woman's Auxiliary to the Winnebago County Medical Society
Auxiliary Pledge — Mrs. Eugene T. McEnery
Business Session
Credentials and Registration — Mrs. Samuel G. Plice
Convention Rules of Order—Mrs. A. C. Mohaupt
Adoption of Convention Program
Appointment of Reference Committees
Appointment of Reading Committees
Appointment of Committee on Courtesy and Resolutions
Report of Revisions Committee — Mrs. Warren W. Young, Chairman
The Benevolence Fund and Its Financial Status—Harold M. Camp, M.D.
Convention Announcements — Mrs. Nicholas G. Chester
Guest Speaker—JUDGE VERA BINKS, Director of Department of Registration and Education, State of Illinois, Springfield.

11:00 A.M.—Reference Committee I — Room No. 108
Reports of Officers and Directors. Guests welcome

A.

Mrs. William Somerville, Chairman
Mrs. R. E. Miltenberger
Mrs. Charles W. Young
Mrs. Charles H. Drenckhahn
Mrs. James Marshall

12:00 P.M.—Reference Committee II — Room No. 110
Reports of Standing Committees. Guests welcome

B.

Mrs. J. Van Prohaska, Chairman
Mrs. Douglas Hurley
Mrs. H. E. Schoonover
Mrs. L. B. Shpiner
Mrs. Fred C. Endres

1:30 P.M.—Reference Committee III — Room No. 111
Reports of Councilors—Guests welcome

C.

Mrs. C. W. Stegman, Chairman
Mrs. B. E. Montgomery
Mrs. Leo Grzesk
Mrs. M. M. Hoeltgen
Mrs. W. C. Schrivner

2:30 P.M.—Meetings—Guests welcome
County Legislative Chairmen — Room No. 113
Mrs. Walter Shriner, presiding
Speaker, Mr. Joseph Stetler, A.M.A.

County Public Relations Chairmen — Room No. 106
Mrs. Edward G. Warnick, presiding
Speaker, Mr. Leo Brown, A.M.A.

County Program Chairmen—Room No. 110
Mrs. A. T. Kwedar, presiding
Speaker, Mrs. E. M. Egan. (Round Table)

County Today's Health Chairmen — Room No. 108
Mrs. Gregory Carey, presiding
Speaker, Mr. William W. Hetherington, A.M.A.

County Benevolence Chairmen—Room No. 111
Mrs. George W. Koivun presiding
Speaker, Dr. Robert H. Hayes

County Bulletin Chairmen—Room No. 103
Mrs. John T. Boswell, presiding
Speaker, Mrs. James P. Simonds
Mr. Roy Gibbons, Chicago Tribune

4:00 P.M. County Treasurers—Room 103
Mrs. S. M. Hubbard, Presiding
Speaker: Mr. Joseph J. Kaberna, Vice President, Chemical and Drug Division, First National Bank of Chicago

County Secretaries—Room 106
Mrs. W. T. Shaffer, Presiding
Mrs. R. E. Dunlevy, Presiding
Speaker: Mrs. Arthur G. Mohaupt, Guest Secretary Panel.

County Press & Publicity, Archives, etc. —Room 108

Mrs. Carl Sibilsky, Presiding
Subject: "Cures for Your Publicity Headaches"
Moderator: Miss Evelyn S. Nelson, Director of Public Relations, Blackstone Hotel, Chicago
Round Table: Miss Isabelle Rice, Club Editor, Chicago Herald American
Mrs. Irene Powers, Club Editor, Chicago Tribune
Mrs. G. T. Buttice, Publicity Chairman of the Woman's Auxiliary, Chicago Medical Society

Members at Large—Room 110
Mrs. G. H. Edwards, Presiding
Speaker: Miss Kris Peterson, Department of Public Relations, American Medical Association, Chicago.
Tea for all members at large

7:00 P.M. ANNIVERSARY BALL for Doctors and Wives—Grand Ballroom
Dinner from 7:00 to 10:00
Entertainment and dancing 8:30 to 12:00

Wednesday, May 20

9:30 A.M.—Memorial Service—Bal Taberin
Organ—Mr. Don DeVale
Lord's Prayer—Mrs. John S. Curtis

10:00 A.M. — General Sessions of the Woman's Auxiliary to the Illinois State Medical Society—Grand Ballroom
Mrs. Harlan English, President, presiding.
Auxiliary Pledge — Mrs. Leo P. A. Sweeney
Courtesy and Resolutions—Mrs. W. C. Bornemeier
Credentials and Registration — Mrs. Samuel G. Plice
Report of Reference Committee I—Mrs. Wm. Somerville
Report of Reference Committee II—Mrs. J. VanProhaska
Report of Reference Committee III—Mrs. C. W. Stigman
Report of Nominating Committee—Mrs. D. C. Good
Election of Officers
New Business
Convention Announcements — Mrs. Nicholas G. Chester
Guest Speaker—Mr. John Nuveen, President of the Chicago Sunday Evening Club Subject, "Peace and Politics"

1:30 P.M.—Anniversary Luncheon—Bal Taberin Honoring Mrs. Harlan English, outgoing President, and Honoring Mrs. Ralph Eusden, President Woman's Auxiliary to the American Medical Association. All Past State Presidents.
Introduction of guests at speaker's table—Mrs. Harlan English
Introduction of Speaker Mrs. James P. Simonds
Speaker—Mrs. Ralph Eusden
Style Show—Mrs. M. M. Hipskind
Installation of Officers—Mrs. James M. McDonnough

4:30 P.M.—Post Convention Board Meeting—Room No. 103
Mrs. Henry Christiansen, presiding

Thursday, May 21

11:30 P.M.—Brunch—Pump Room of the Ambassador East Hotel
Honoring Mrs. Henry Christiansen, newly installed President.

We wish to express our sincere gratitude to Dr. Harold M. Camp, Mrs. Frances Zimmer, Miss Ann Fox, Mr. James Leary, and the Illinois State Medical Society for their assistance and cooperation.

COMMITTEES

LOCAL COMMITTEE ON CONVENTION ARRANGEMENTS

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Mrs. Nicholas G. Chester

Honorary Committee

Mrs. Warner Newcomb

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Installation of Officers

Mrs. James M. McDonnough

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1. Mrs. William Somerville, Chairman of Committee I
2. Mrs. J. VanProhaska, Chairman of Committee II
3. Mrs. C. W. Stigman, Chairman of Committee III

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Mrs. C. L. Bennett, Chairman

Wednesday Anniversary Luncheon

Mrs. Warren W. Young, Chairman

Mrs. M. M. Hipskind - Mrs. William Somerville, Co-Chairmen

Mrs. W. C. Bornemeier	Mrs. O. C. Julian
Mrs. C. David Brown	Mrs. E. T. McEnery
Mrs. John F. Flynn	Mrs. F. J. Moore
Mrs. M. Hoeltgen	Mrs. S. J. Sullivan
Mrs. Wm. Jakopich	Mrs. O. E. Veneklasen

Past Presidents participating in Luncheon Entertainment

Mrs. G. H. Mundt	Mrs. Lee N. Hamm
Mrs. Lucius Cole	Mrs. M. A. Nix

Thursday's Brunch honoring

Mrs. Henry Christiansen, State President

Mrs. Garland Brown, Chairman

Mrs. Henry Schorr, Co-Chairman

Mrs. John F. Flynn

Hospitality Committee

Mrs. Frederick Tice, Chairman

Mrs. Holland Williamson, Co-Chairman

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Hospitality for State Presidents

Mrs. Arthur G. Edison, Chairman

MAKE HOTEL RESERVATIONS EARLY FOR THIS VALUABLE MEETING

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



School Health in Illinois

George L. Drennan, M.D.
Jacksonville

A discussion of school health in Illinois should begin and end with the statement "The Health of School Children" is "Everybody's Business" and the only way to accomplish the goal of perfection is by "Everlasting Teamwork."

The definition of health formulated by the World Health Organization should be kept in mind: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." All Children in the state should have the benefit of adequate total health supervision from birth through adolescence to aid them in attaining such a state of health. In Illinois with its existing and potential resources, it should be possible to achieve this goal of providing adequate total health supervision for all children in the state.

The well-being of our children is of the utmost importance now and in the future. To promote and maintain our children's health is everybody's business and demands everlasting teamwork. The time has come when we need no longer deliberate at length about principles, since these have been carefully tried out, revised, and now reasonably well established. There is no necessity for awaiting further the development of any techniques, because we have good tools and good methods with which to work. The game has been held up by the lack of that teamwork between physicians, dentists, educators, nurses and parents and through which we will be able to harness the forces at our command and put them to work, realizing at last the fruits of what Kipling had in mind in his verse:

"It ain't the individual
Or the Army as a whole,
But the everlasting team-
work of every bloomin' soul."

Interest in school health has spread across the country like epidemic during the past several years. This interest has not been confined to any one group or to any section of the United States. Educators, physicians, dentists, nurses, parents, and many others, along with the organizations to which they belong have all been involved. Among the indications of this increased interest are the development of school health councils, the formation of school health com-

mittees in medical societies, the institution of health courses in teachers' colleges, and the holding of meetings, conferences and institutes on school health.

Why this growing concern, this growing interest in school health? Perhaps it is because the school's opportunities for health education and its obligations for health supervision are becoming more clearly defined. Certainly the law requiring health examinations three times during school life has focused attention on this activity in Illinois. A review of some of these opportunities and obligations in order of their priority for children, may help us to think together:

1. During the school term children are confined in classrooms several hours each day. This demands development and maintenance of a school environment that will promote mental and physical health.
2. The school situation brings pupils together in large groups at a time in their lives when they are very susceptible to the common diseases of childhood. This demands carefully determined policies for prevention and control of communicable disease.
3. Even in the best organized school some accidents and sudden illness are bound to occur. This requires a carefully worked out program to cope with emergencies and to meet disaster situations.
4. The school years present an unparalleled opportunity for health education of all of our people during the formative years of their lives. This means that if we are to take advantage of this opportunity, a well-organized program of health instruction is essential to lay the groundwork for healthful living throughout life.
5. Only a child who is in the best possible health can profit fully from his school experience. This makes essential procedures to single out children with conditions that may interfere with learning, and a follow through to assure their correction or adjustment.
6. Modern conditions of living encourage an arm chair or sedentary existence. This necessitates a program of physical education adapted to individual needs to provide skills that will serve as an incentive to wholesome physical recreation throughout life.

Even a cursory study of these factors makes it clear that the development of a school health program is a complex task—too big for any one agency or group to achieve alone. It is obvious that the efforts of parents, teachers, nurses, physicians, dentists and many others will be needed and that each of these has certain responsibilities.

First priority in responsibility for the health of children rests with the parents. They have the obligation to provide conditions in the home that will be conducive to health and to provide adequate medical and dental care. The family physician and dentist serve as health advisors to the family and render needed diagnostic and treatment services. The health department furnishes preventive and protective services for the entire community including school children. The school supplements and reinforces the efforts of the home and has the obligation to provide conditions and educational services conducive to health. Various voluntary health agencies make important contributions with particular emphasis on certain special health problems.

The integration of all these functions requires the closest cooperation and challenges all concerned. But in this country we have an answer to this kind of challenge. It is an answer typical of our democracy—the good old American system of teamwork. It is a system that again and again throughout history has proved superior to any other.

How can we get this kind of teamwork in school health? How can we develop school health policies that will be acceptable to all those who are expected to carry them out?

There is a principle of good teamwork involved that may hold the secret of success in this project. It is, *mutual respect for each others' skills and responsibilities.*

Good teamwork demands that the educator turn to the physician and dentist for advice on the medical aspects of school health. Similarly the physician and dentist defer to the educator on questions of teaching techniques and procedures. Both seek the counsel of those trained in public health on problems in this field. And all have in mind the fundamental responsibilities of the parents for the health of their children.

Trust, faith and goodwill will grow and prosper in this kind of relationship. This does not

(*Continued on page* 243)

KNOW YOUR SOCIETY

THE HOUSE OF DELEGATES

Again we turn to the Constitution and By-Laws to give you the general outlines of the development of the House of Delegates.

The House of Delegates shall consist of:

(a) delegates elected by the component societies (one delegate for every 75 members of major fraction thereof)

(b) the councilors

(c) ex-officio, the president, president elect, vice presidents, and the secretary-treasurer.

It shall be the legislative body of this Society and shall conduct all business except such as is otherwise provided for by the Constitution and By-Laws.

All recommendations of the House of Delegates dealing with the acquisition or disposal of property of any kind, or with the appropriation or expenditure of funds, must be approved by the Council.

The House of Delegates shall meet annually at the time and place of the annual session of this Society, and shall fix its hours of meeting so that they shall not conflict with the general meetings of the Society.

Special meetings of the House of Delegates may be called by the president and the chairman of the Council, or shall be called on petition of twenty component societies.

The House shall give diligent attention to and foster the scientific work and spirit of the Society, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest.

(Therefore, every member of the House, has a responsibility to assist in making the annual meeting of this Society a success from the scientific standpoint, from the standpoint of attendance, progress, etc.)

The House elects:

(a) officers of this society

(b) Delegates and alternates to the A.M.A.

(c) Members of constitutional committees

(d) Councilors

The House has the power to divide the state into Councilor Districts specifying which counties each district shall include.

The President of the Society presides at meetings of the House. He appoints the Reference Committees at the organization meeting of the House the first day of the annual session.

BEHIND THE SCENES — before the Reference Committees — the heavy work of the House is conducted. These Reference Committees hold public hearings. As a physician you are entitled to attend any or all these sessions.

All reports published in the HANDBOOK are referred to the proper committee; all supplementary reports presented on the floor of the House are typed up and given to the correct committee. Any physician interested in any

particular phase of society work can appear before these committees to discuss his own or his society's attitude toward any question.

The Reference Committee prepares a report to the House, and makes recommendations which the House may accept or reject. Any member of the House has floor privileges and may speak to any question up for consideration.

Any physician may request the floor, and may be granted the right to speak.

The House of Delegates has the power to fix the amount of dues for the ensuing year, and the amount of these dues includes the annual subscription to the Illinois Medical Journal. The division of dues is approved by the Council, following recommendations from the House. As an example, the Council approved the division of dues recommended for 1953:

General funds of the Society	$18.00
Benevolence fund	2.00
Am. Medical Education Foundation	20.00
	$40.00

The House of Delegates belongs to the members of the Illinois State Medical Society. The county society elections provide the membership of the House; the actions of the House provide the "rules and regulations" under which all phases of Society activity operate.

As a member you can work constructively to better your Society by a sustained and active interest in the problems which come before the House of Delegates for consideration.

If you are not a member of the House, your interest can be developed by reading the transactions and becoming familiar with the activities and projects under consideration.

If you lack interest, fail to participate in society activities at the county level, if you fail to express your opinions and contribute your thoughts, you must refrain from criticizing the honest efforts of physicians taking an active part in Society affairs.

THE COUNCIL

To quote from the Constitution and By-Laws:

The Board of Trustees, or, as in the Constitution and By-Laws designated, THE COUNCIL, whose duties are executive and judicial, shall consist of 16 councilors elected by the House of Delegates (six shall be chosen from District 3 (Cook County), and one from each of the other ten Districts) and one councilor-at-large (the retiring president) who shall serve a term of one year, with the president, president elect and secretary-treasurer ex-officio.

The Council shall have charge of and control of all property belonging to this Society of whatsoever nature, and of all funds belonging to this Society from whatsoever source.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Council.

The Council shall formulate rules governing the expenditure of money to meet the running expenses and fixed charges of the Society, as well as such other rules governing its actions as it may deem necessary or desirable.

The Council may authorize the remission of dues of any member on recommendation of his county medical society for reason. In such cases, the secretary of the State Society shall recommend remission of dues by the American Medical Association.

The Council shall meet daily during the annual session of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the councilors. It shall elect a chairman who shall make an annual report to the House of Delegates.

Each Councilor shall be organizer, peacemaker and censor for his District. He should visit the counties in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each county in his district to the Council and to the House of Delegates.

The Council shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature before the House of Delegates or the general meetings, shall be referred to the Council without discussion. It shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Council shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and By Laws of the American Medical Association.

The Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated, so as to distinguish them from district societies, and these societies when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

(For example: Coles-Cumberland Medical Society; Will-Grundy Medical Society; Jefferson-Hamilton Medical Society)

The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

(The Council is responsible for the publication of the Illinois Medical Journal.)

The Council shall employ annually a certified public accountant to audit all accounts of the Society and present a statement in its annual report to the House of Delegates. This report shall specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

In the event of a vacancy in the office of the secretary-treasurer, the Council shall fill the vacancy until the next annual election.

If during the interval between two annual meetings, sickness, death or removal from the state or councilor district, or any other reason, prevents a councilor from attending to the duties of his district, or if he shall be absent from two consecutive meetings of the Council, his office may be declared vacant at the discretion of the Council. The Council shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

It is the duty of the Council to appoint the Committee on Arrangements whose duty it is to provide suitable accommodations for the annual meeting of the Society.

The Council shall be entirely responsible for the selection of ethical exhibits for the annual meeting.

The Council functions as the governing body of the Society between meetings of the House of Delegates.

The Council supervises the work of some 30-35 committees conducting state wide activities.

The Council determines QUESTIONS OF POLICY until such time as the House can act.

The Councilor "shall be organizer, peacemaker and censor for his District" Due to a typographical error, this once appeared: "Shall be organizer, PACEMAKER and censor for his District. Perhaps the error is a good one, and should be allowed to stand.

County societies are privileged to call upon the Councilor for their District at any time. The Councilor presents the Fifty Year Club certificates in his district. He checks to see that those physicians eligible for Emeritus membership are honored if the individual so desires.

The Councilor, plus the President and Secretary, constitute the Ethical Relations Committee in county societies too small to have such a committee.

His fingers should be on the pulse of every county society in his district. He should bring county society problems to the attenion of the Council, and help solve any difficulties existing in his District.

The County Medical Societies in Illinois should learn to "use" their Councilor, and help him to represent them thoroughly and efficiently at the state society level.

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR MAY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the May schedule of clinics for physically handicapped children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The May clinics are:

May 1, — Evanston, St. Francis Hospital

May 5, — Casey, High School

May 5, — Pittsfield, Illini Hospital

May 6, — Hinsdale, Hinsdale Sanitarium

May 7, — Monticello, Lincoln School

May 8, — Chicago Heights (Rheumatic Fever), St. James Hospital

May 12, — East St. Louis, Christian Welfare Hospital

May 12, — Peoria, St. Francis Hospital

May 13, — Joliet, Will County T.B. Sanitarium

May 14, — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

May 14, — DuQuoin, Marshall-Browning Hospital

May 14, — Springfield, St. John's Hospital

May 20, — Evergreen Park, Little Company of Mary Hospital

May 20, — Shawneetown, Stanelle Medical Center

May 21, — Rockford, St. Anthony's Hospital

May 22, — Chicago Heights (Rheumatic Fever), St. James Hospital

May 26, — Effingham (Rheumatic Fever), Douglas Township Building

May 26, — East St. Louis, St. Mary's Hospital

May 26, — Peoria, St. Francis Hospital

May 27, — Aurora, Copley Memorial Hospital

May 27, — Alton, Alton Memorial Hospital

May 27, — Springfield (Cerebral Palsy), Memorial Hospital

May 28, — Bloomington, St. Joseph's Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Chidren's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local

chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilitites for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

BULLETIN OF THE WOMAN'S AUXILIARY TO THE A.M.A.

The Bulletin of the Woman's Auxiliary to the American Medical Assn was established in 1939 under the supervision of the Advisory Council of the American Medical Association, in which is published all Official Auxiliary notices and transactions of the Conventions and abstracts of the meetings of the Board of Directors. The Bulletin is the official publication of the Woman's Auxiliary to the American Medical Association. The material in the Bulletin is selected by the publications committee with the idea of giving to its members of the Woman's Auxiliary, information and suggestions that will be of interest to them and help them in their Auxiliary work. The Bulletin was established and is maintained for the sole purpose of giving its members authentic information concerning all Auxiliary activities; It has regularly published addresses given by distinguished physicians and guests before Auxiliary gatherings: articles prepared by officials and directors of Bureaus and Councils of the American Medical Association. Articles dealing with special topics prepared by Auxiliary officers, Chairmen of Committees and other members well informed on Auxiliary procedure; editorials prepared by members of the Editorial Committee; and reports by Presidents of the State Auxiliaries which furnish a medium for the exchange of ideas among Auxiliary workers throughout the country.

Inasmuch as the Bulletin is the official publication of the Woman's Auxilary, its aims, its purpose, and its objectives must be the same as those of the Woman's Auxiliary, these objectives are:

1—To assist the American Medical Association in its program for the advancement of medicine and public health.

2—To coordinate and advise concerning the activities of constituent auxiliaries.

3—To cultivate friendly relations and promote mutual understanding among physicians' families.

Every issue of the Bulletin is planned with these objectives in mind. The Auxiliary is not an independent organization and, therefore, the Bulletin, its official publication, is not an independent magazine. Neither its policies or the program of the Auxiliary can be changed without specific approval of the American Medical Association.

Every Auxiliary Member should subscribe and read the Bulletin, it provides information which every member can profitably use, whether she is an officer, a chairman or just a member. Bulletin not only informs our members of the excellent work being done by the state and territorial auxiliaries, but it prepares them for work as chairman and county officers.

Despite the continuous rise in the cost of material and labor the yearly subscription price of one-dollar has remained the same, for the Bulletin was established with no idea of its becoming a money-making project. The Bulletin is published quarterly, August, December, March, and May, the cost of the four issues for the year is One Dollar (1.00).

It is up to every member of the Woman's Auxiliary, to be a well informed efficient auxiliary member and to subscribe to and read the Bulletin. Please note: Subscriptions, to be sent to: — Bulletin Chairman *or*, Miss Margaret Wolfe, Executive Sec'y, 535 North Dearborn Street, Chicago 10, Illinois.

Mrs. John T. Boswell
Bulletin Chairman,
Woman's Auxiliary to the Illinois
State Medical Society.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago, Ill.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2 and 3. All sessions will be open to members of the

medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

THE AMERICAN COLLEGE OF ALLERGISTS

The annual conclave of The American College of Allergists will be held this year at the Conrad Hilton Hotel in Chicago April 24 to April 29.

The first four days will be devoted to instruction under the tutelage of recognized authorities and the last three to a discussion and reporting of recent advances in the field of allergy by the investigators themselves. For detailed information write The American College of Allergists, La Salle Medical Building, Minneapolis 2, Minnesota.

ESSAY AWARD FOR PHYSICAL MEDICINE AND REHABILITATION

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a prize for an essay on any subject relating to physical medicine and rehabilitation. The contest, while open to anyone, is primarily directed to medical students, internes, residents, graduate students in the preclinical sciences and graduate students in physical medicine and rehabilitation.

The following rules and regulations apply to the contest:

1. Any subject of interest or pertaining to the field of physical medicine and rehabilitation may be submitted.

2. Manuscripts MUST BE in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, not later than June 1, 1953.

3. Contributions will be accepted from medical students, internes, residents, graduate students in the pre-clinical sciences, and graduate students in physical medicine and rehabilitation.

4. The essay must not have been published previously.

5. The American Congress of Physical Medicine and Rehabilitation shall have the exclusive right to publish the winning essay in its official journal, the Archives of Physical Medicine and Rehabilitation.

6. Manuscripts must not exceed 5000 words (exclusive of headings, references, legends for cuts, tables, etc.), and the number of words should be stated on the title page. An original and one carbon copy of the manuscript must be submitted.

The winner shall receive a gold medal properly engraved, a certificate of award and an invitation to present the contribution at the 31st Annual Session of the American Congress of Physical Medicine and Rehabilitation at the Palmer House, Chicago, August 31 through September 4, 1953.

NEW OFFICERS

The Central Association of Obstetricians and Gynecologists announce the election of the following officers: President, W. O. Johnson, M.D., Louisville, Kentucky; President Elect, Harold C. Mack, M.D., Detroit, Michigan; Vice-President, Arthur B. Hunt, M.D., Rochester, Minnesota; Secretary-Treasurer, Harold L. Gainey, M.D., Kansas City, Mo.; Assistant Secretary, Woodard D. Beacham, M.D., New Orleans, La.

These officers will serve until the end of the Annual Meeting which will be held at the Shamrock Hotel, Houston, Texas, on November 5, 6 and 7, 1953.

The business office of the Central Association of Obstetricians and Gynecologists is located in Suite 602, 116 So. Michigan Avenue, Chicago 3, Illinois. The office of Dr. Harold L. Gainey, Secretary-Treasurer, is located at 4635 Wyandotte Street, Kansas City, Missouri.

ORIGINAL ARTICLES



Endocrine Disorders in Office Practice

James H. Hutton, M.D.
Chicago

Office practice is undoubtedly less spectacular and less thrilling than hospital work in general and surgical work in particular. However, it has its share of tragedy, drama and heartening experiences in the way of relieving patients of long-standing disabilities, either physical or emotional or both. There is some satisfaction in assisting a couple to overcome a childless marriage or in speeding the development of a backward youngster whether the retardation is in the physical or mental sphere.

If we do office work carefully, many patients can be spared the trouble and expense of hospitalization. At the same time hospital beds, now in great shortage, can be made available for more acutely ill patients.

This discussion deals only with ambulatory patients. They can walk out of our offices as easily as they walk in, if our services fail to please them. We have far less control over the situation than when the patient is in the hospital. There the physician can order such laboratory work as he desires and the patient is not in a position to argue about it. In the office, procedures often have to be explained and justified to the patient's satisfaction. The patient and his family and friends consider themselves competent judges as to the quality and acceptability of our services.

Office practice is often a matter of compromise. We have to settle for something less than scientific accuracy in diagnosis in order to meet the conditions imposed by the patient's financial status and emotional reactions. Therefore we have to depend more on the history, physical findings and simple laboratory procedures. There is no point in ordering $100 or $200 worth of laboratory tests for the patient making $50 or $75 per week. He simply will not tolerate it as long as he is ambulatory.

Maybe this calls for a larger measure of psychosomatic medicine than is necessary in hospital practice. However, there are some compensatory features. Since the patient is not away from his job nor confined to an expensive bed, more time can be taken for study.

We should never forget that every patient who consults us does so because he has troubles and is hopeful — though maybe not too optimistic

Delivered before the Fulton County Medical Society Nov. 12, 1952.

— that we shall be able to relieve him. No one comes to see us simply because he likes us. We are rarely better than lesser of two evils.

The patient wishes to talk about his troubles, not listen to a recital of ours. Often our greatest service is to listen to the patient's recital of his woes. This was once referred to as mental catharsis. The most valuable data are often furnished by the history.

Generally we need to know three things: What? When? How?

WHAT are the complaints? The patient is encouraged to name all complaints with the assurance that the physician will separate the important from the irrelevant facts. Even when thus encouraged the patient often fails to give a complete inventory of his complaints at the first interview. This is not because of any wish to conceal anything but because he — or more often she — simply did not happen to recall some items or considered them unimportant.

WHEN did these things begin? A week, a month or decades ago? The answer to this question often connects the symptoms with some etiological event.

HOW are they related to food, to the menstrual periods, time of day, the weather?

The patient with hypopituitarism or hypoadrenia with hypoglycemic symptoms feels worse if he goes too long without food. If the symptoms occur about the same time each day they may be prevented or minimized by taking food an hour before time for them to occur. The occurrence of such a series of events suggests a glucose tolerance test. A low sugar curve is common in these two conditions.

Patients with hypothyroidism are sensitive to cold, require more clothing, bed covering, etc., than the normal person. They enjoy warm weather.

Patients with Addison's disease — and probably lesser degrees of adrenal insufficiency — are sensitive to cold but are equally sensitive to hot weather.

Symptoms occurring at the time of the menstrual periods are usually due to some pituitary or ovarin dysfunction.

How is the onset of the symptoms related to infection, operation, pregnancy, injury? Frequently hypopituitarism has its onset soon enough after such an event as to suggest a casual relationship.

It is important to know about the patient's developmental history — whether walking and talking began at the usual age, and whether the teeth appeared at the normal age. All of those events are delayed in hypothyroidism. Patients with hypopituitarism often have difficulty in stopping nocturnal enuresis. They may break the habit only to have it recur some years later.

In addition to the usual complete physical examination special attention is paid to the height and weight of the patient, the distribution of the obesity, the condition of skin (whether it is dry and coarse as in hypothyroidism or soft, delicate and easily bruised as in hypopituitarism and whether striae are present as in Cushing's syndrome) and the amount, distribution and character of the hair suit. The hair is likely to be dry and brittle in hypothyroidism with very little on the extremities. In hypopituitarism it is usually fine and silky and rather scant.

Perhaps no department of medicine has a larger assortment of laboratory procedures available to it than has endocrinology. This very fact urges caution in the selection of tests. We should attempt to save the patient needless expense. Fortunately, as time goes on we are able to simplify some laboratory procedures and at times to dispense with some. For instance, when Cortisone first became available most patients were hospitalized and a great deal of laboratory work was done for them. This, together with the cost of the medication, led to what were referred to as "Cortisone bankrupts." Now most patients are not hospitalized. Much of the laboratory work previously used can be dispensed with, and the pharmaceutical manufacturers have reduced the price of Cortisone to a fraction of its former cost.

In spite of the cost of laboratory procedures and some medicaments the current complaint about the high cost of medical care is unjustified. It is cheaper now than ever before and of a better quality. The increased length of life brought about by preventive and curative medicine can hardly be evaluated in terms of dollars. Many diseases have been almost or completely eradicated (cholera, typhoid, smallpox, diphtheria and scarlet fever). Others have been reduced to the status of a minor illness that lays the patient up but a short time.

Our therapeutic armamentarium is enriched

by products synthetic and otherwise that were not available at any price even ten years ago. For instance, about the middle of last century cattle sold for about $7.50 a head and quinine cost $6 to $8 an ounce. Now we have a synthetic preparation one dose of which is said to cure malaria and the cost is a matter of a few cents. The length of time that patients have to spend in hospitals for various ailments has been greatly reduced. So the saving of life, time and money brought about by modern medicine makes the cost of medical care very cheap indeed.

Office practice is most often concerned with disorders of growth, the menstrual or reproductive function, and neurotic symptoms.

There is still some argument as to whether the fat boy with hypogonadism should be called "a Froehlich" and whether he should have any treatment. The name is of no consequence so long as we all know what kind of a patient we are talking about.

Regarding treatment: It is argued by some that these youngsters should have no treatment until their middle teens because nature unassisted will take care of the situation. Many of us know that nature does not bring all these youngsters up to normal and that in such cases valuable time is lost — and some stigmata are acquired that cannot be removed. Hence some argue that we should offer all of these boys the benefit of treatment since it is safe and easily given.

This treatment consists of thyroid in tolerance doses; gonadotropins in doses of 100 to 500 units once or twice a week depending on the patient's convenience; and posterior pituitary extract in doses just short of the amount which causes annoying symptoms of nausea, faintness or intestinal cramps. If the genitalia are too slow in developing, some androgenic preparation may be given one week out of each month. This could be methyl testosterone sublingually 5 or 10 mg. per day or testosterone propionate 25 mg. twice weekly. During the use of the gonadotropins the urine should be examined for sugar every three months.

I rarely give any hypodermic medication before the twelfth year. In earlier years small doses of thyroid hasten development.

A simple dietary measure for fat children is to ask them not to take pie, cake, candy, cookies, ice cream or soft drinks and to eat sparingly of bread, butter, potatoes, gravy, peas, beans and corn.

Treatment should be continued until the genitalia attain normal proportions. The frequency of injections should be decreased as improvement occurs. In cases of cryptorchidism one may expect normal descent and development if the testicle can be palpated in the canal and is not mechanically prevented from descending. I have never seen descent occur when the testicle could not be palpated in the canal.

Children who fail to grow at a normal rate present a difficult problem. Assuming — a very large assumption indeed — that non-endocrine factors have been excluded, a number of endocrine preparations are available for treatment. One is thyroid in tolerance doses. There is no occasion for frequent determination of the B.M.R. By checking the pulse rate, the presence or absence of tremor of the outstretched fingers and whether the patient is nervous or has difficulty in sleeping, the physician can easily and safely determine the correct dose of thyroid. It is given in most endocrine deficiencies as a sort of synergist for whatever other endocrine medication is being given.

Androgens are sometimes helpful: Methyl testosterone 10 to 30 mg. daily; testosterone propionate 25 mg. two or three times a week; or Stenedione 35 mg once a day. One should guard against precocious development by occasional inspection of the genitalia. If androgens are given to girls, the patient should be seen frequently to guard against the development of signs of masculinity. A change in the voice seems to be one of the early signs. The androgen should be stopped at once if signs of masculinity appear.

Gonadotropins 200 to 500 units two or three times per week.

Anterior pituitary extract of 0.5 cc. two or three times per week. This may be given with the gonadotropin. This is an unstandardized pituitary extract — for many years marketed as ANTUITRIN. It is not Council accepted. One recommends the use of such preparations with some hesitancy, but this has seemed helpful in so many cases that I take the liberty of recommending its use in such of these cases as do not yield to other measures.

There is no longer any good reason for allowing children to attain the grotesque stature of

the giant. By irradiating the pituitary, the growth can be stopped. This is a perfectly safe procedure. It should not be given until one makes certain that the child is not already about to stop growing. Roentgenograms of the hip, knee and ankle should be secured to determine the status of the epiphyseal unions. If these are nearly complete, very little further growth should be expected. However, if the epiphyseal lines are wide open considerable further growth may be expected.

X-ray treatment consists of one treatment each week until eight are given for a total of 900 r. Occasionally a second series is necessary and, rarely, a third. The only inconvenience is some temporary loss of hair in a few cases.

Quite frequently patients have some endocrine disorder and also some disturbance in the mental or emotional sphere. Two problems arise. First, not to overlook the psychogenic nature of some of the patient's symptoms. Second, not to overlook the physical complaints merely because of many in the emotional sphere. Should the patient then be referred to a psychiatrist at once or should we undertake the correction of the patient's endocrine dysfunction hoping that that will also take care of the psychogenic part of the picture? I doubt whether either the psychiatrist or the endocrinologist can answer that question prior to a therapeutic trial.

For my guidance I have set up a few rules to warn me that part of all of the patient's complaints may be a neurotic basis. These rules are about as follows:

1. Complaints that are bizarre, unusual and point to no organ or system as being responsible.

2. A long history of having had many careful examinations by competent physicians, x-ray studies, etc., etc., without any diagnosis having been made.

3. Bizarre reactions to medication. In this case the use of a placebo will be helpful. If the same reactions follow it as accompany other medication, we can be certain of the psychogenic nature of the symptoms. That, however, makes them no less real or difficult to cure.

The question is which should be treated first.

I have seen the situation work both ways. Some years ago I saw a nurse who complained of many menopausal symptoms and also of symptoms of an anxiety neurosis. Treatment of the menopause helped scarcely at all. In two or three sessions the psychiatrist completely relieved her.

The opposite situation is represented by the woman who had many symptoms apparently on an emotional basis. Psychiatric therapy including shock treatment did not help. Treatment of the accompanying pituitary-ovarian disturbance was accompanied by considerable relief.

Recently a 41-year-old woman came in complaining of severe headaches which had begun definitely 17 years before. Though she had had some slight headache before that, the headaches had developed their present status immediately after an unhappy marriage. She also has some endocrine disorders the treatment of which seems to aff ord her no relief.

Menstrual Disorders. While most cases of this kind are taken care of, at least initially, in the office, a paper of this nature can discuss the subject only superficially. Only a few suggestions are offered. It is assumed, of course, that reasonable precautions are taken to exclude non-endocrine causes.

For amenorrhea we have for treatment the following measures:

1. A reducing diet in the overweight. A history of rapid gain in weight with coincident decrease in the frequency or quantity of the menstrual flow points to the pituitary as the causative factor. Study should be undertaken to determine whether hypopituitarism is present. Frequently the treatment recommended for the Froehlich type of youngster is indicated in the obese amenorrheic woman.

2. Thyroid in tolerance doses.

3. Gonadotropins.

Equine, 1000 units, alternate days for 2 weeks, plus chorionic gonadotropin 1000 units once a day for 10 days.

4. Estrogen and progesterone:

For secondary amenorrhea — duration of less than 2 years.

Estradiol benzoate 2.5 mg.
Progesterone 12.5 mg. } daily for 2 doses.

For secondary amenorrhea — duration more than 2 years.

Progesterone 10 mg. once a day for 5 days.

For primary amenorrhea

Estradiol benzoate 1 mg.
Progesterone 10 mg. } once a day for 5 days

5. Low-dosage irradiation of the pituitary and ovaries — 50 r at weekly intervals for 3 doses.

Dysfunctional Uterine Bleeding.

A. For women in the childbearing age:

1. To stop the bleeding:
 (a) Pitressin tannate in oil 2 cc. daily
 (b) Chorionic gonadotropins
 1000-5000 units alternate days from day 13 to 23 for 3 cycles
 1000 units daily while bleeding
 (c) Methyl testosterone — 5 to 30 mg. daily
 (d) Estrogens:
 Stilbestrol 10-30 mg. injected into the cervical tissue
 Stilbestrol 5 mg. once a day for 5 days or some other estrogen in comparable doses.
 (e) Progesterone
 30 mg. once a day for 7 days followed by a second and third course at monthly intervals.
2. To prevent recurrence:
 (a) Reduction diet
 (b) Vitamin B complex (orally, parenterally or both)
 (c) Thyroid in tolerance doses
 (d) Insulin for the underweight
 (e) Low-dosage irradiation to the pituitary and ovaries.

B. Pre and post menopausal age:
Testosterone 10 mg. or more daily.
Low-dosage irraditation to the pituitary and ovaries.

It will be noted that practically the same agents are used in amenorrhea and excessive bleeding. The difference is in the size of the dose, smaller doses for amenorrhea, larger for the bleeding.

The Menopause: Many women require nothing more than mild sedatives. If these are not sufficient, estrogens should be given in doses just sufficient to control the symptoms. The reasons for this precaution are two: First, and in general, the smallest dose of medication that will accomplish its purpose is the optimal dose. Second, some women are helped by small doses (2000 units once or twice a week) but feel worse when larger doses (10,000 to 20,000 units) are given. Natural estrogens are superior to the synthetic ones for the more troublesome complaints.

We have to be careful in office practice that patients do not come to rely on us and our medicaments more than they should. The situation is likely to develop before we are conscious of it. Once developed, it is difficult to correct.

SUMMARY: It is pointed out that while office practice is less spectacular than hospital work, it has some compensatory features. If well done, it saves patients the trouble and expense of hospitalization and releases hospital beds for patients acutely ill.

Diagnoses must be made with a minimum of laboratory work. An accurate and detailed history furnishes much valuable data.

Endocrine office practice is largely concerned with disorders of growth and development, of menstruation, and of patients with neurotic symptoms who may also have some endocrinopathy. Suggestions are made regarding the treatment of these various disorders.

It is urged that caution be used to prevent patients coming to rely too heavily on the physician.

Obstetrical Hemorrhage

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A few remarks on this subject may well begin with those disturbances during early pregnancy, such as threatened abortion, abnormal placental development, or an abnormal ovum, such as a mole. Any of these are capable of causing bleeding in varying degrees at different times. Of course, the management of these problems is expectant with emphasis on preservation and development of the pregnancy, if possible. Should this not be possible, adequate measures should be instituted at the right time to restore the birth organs back to normal status and correction of blood loss.

Adequate prenatal care, including speculum examination, may reveal a condition of vaginitis, cervicitis, polyp, or cervical cancer. It is well to know that most cases of cervical cancer are missed at first, for there is a tendency to refrain from complete examination because it may jeopardize the existing pregnancy. Good examinations and proper therapy are still preferred over unwise conservatism and a "hands-off" policy. Occasionally an abnormal development of malposition of the uterus may give rise to bleeding during pregnancy — also, there are instances of blood dyscrasias as aplastic anemia or leukemia which we must always keep in mind as etiological factors in hemorrhage. It is also true that too many women die from ectopic pregnancies. It is better to operate after sincerely trying to make the diagnosis than to learn the truth from the autopsy surgeon.

As pregnancy progresses, we approach the more serious and common causes of obstetrical hemorrhage, i.e. placenta previa; premature separation of the placenta; and post partum hemorrhage. Placenta previa might first be suspected during prenatal visits because of a high presenting part, malpresentation, or bleeding. The provisional diagnosis is often confirmed or disproved by radiological study. By a careful prenatal routine some clinics have been able to admit some 20% of women with placenta previa to the hospital before any bleeding occurs. As a generalization, about half will require cesarean section with choice of disposal depending on cephalo-pelvic relationship and placental site. In any event, the first hemorrhage is rarely fatal and may serve as a warning to properly classify the patient, ready your plan of management, and surround her with an environment complete safety. If possible, expectant treatment should be continued until the 36th to 38th week, because prematurity is the most serious fetal hazard. Rh compatible blood should be on hand and the mother should stay in a double or four bed room within reach of a bell, so that immediate alarm can be made at the onset of hemorrhage. Remember, fatal bleeding may result from improper vaginal examination when dealing with placenta previa.

Equally serious is the condition of premature separation of placenta with revealed or concealed vaginal bleeding and progressive shock. Here again, the duration of pregnancy, dilatation of the cervix, and presence or absence of labor all influence the decision on management. All of you are aware of the potential risk in allowing or permitting delivery from below in cases previously sectioned for conditions other than disproportion. Sometimes uterine rupture takes place with very little clinical evidence. Alertness on the potential hazards when dealing with such problems will be a big step forward in caring for the complication if it arises.

With these preliminary remarks we may now turn our thoughts to the greatest single cause of maternal death, namely post partum hemorrhage. The danger from this complication is augmented by excessive gain in weight, long labor, operative delivery, laceration or incision of the perineum, prolonged third stage, excessive sedation, uterine atony, and sometimes poor obstetrics. Therefore, we again come back to the old refrain — one of the axioms laid down by the men who pioneered the organization of this society — namely, good prenatal care. Time and again we realize the significance of those

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three small words. To begin with, a statistical study will reveal that individuals gaining excessively during pregnancy tend to lose more blood than the increase in weight would warrant. Likewise, a neglected secondary anemia may be associated with a decrease in specific gravity of the blood serum which may make for increased bleeding. It is interesting to note in this connection that studies by Weiner, of Harvard University, have shown amniotic fluid would shorten by at least one half the normal coagulation time of freshly drawn venous blood. It is suggested the initiation of clotting of shed intra uterine blood as one of the probable functions of amniotic fluid. It would therefore, play a major role in post partum hemostasis.

Apparently the loss of 500 to 600cc of blood is considered a post partum hemorrhage, but this is arbitrary, for what is considered normal for one patient may be excessive for another. Probably a more accurate gauge would be 1% of the patient's body weight. It is apparent that this phase has been neglected, and would be an excellent subject for further study. Considerable confusion exists in many minds as to the time of doing something about the placenta. A fairly satisfactory method is that advocated by Calkins. By his method, the change in shape of the fundus is a most important sign. When the uterus changes from a discoid to globular shape separation has occurred and the placenta should be expressed.

This brings us to consider some of the other important causes of bleeding, namely the third and so called "fourth stage" of labor: a) vaginal or perineal laceration; bright red bleeding during the second and third stage of labor may be due to spontaneous or traumatic injury to the soft tissues of the birth canal. If the cervix is injured, bleeding is bright red — arterial and spurting in type. b) undesirable delay in expressing the separated placenta allowing a retro placental hematoma to become increasingly larger as time elapses with excessive blood loss. The hematoma is a result of placental separation, and not the cause.

Atony or failure of the uterus to contract is listed as the most frequent cause of post partum hemorrhage after the placenta has been expressed. Here the doctor must be alert and suspect with anticipation the possible occurrence if there is a prolonged labor, twins, hydramnios, fibroids, large baby, or previous uterine surgery such as section, ligament shortening, or myomectomy. The complication is readily diagnosed — a soft, flabby uterus with venous bleeding with very little or no tendency to contract with ordinary measures. Here is where the obstetrician may experience a sinking apprehensive feeling well known to all of you. The wise use of oxytocics, uterine packing, I. V. fluids, and blood may be necessary to turn the condition toward a favorable status.

Occasionally, an intramural or submucous myoma mechanically may prevent the uterus from contracting sufficiently to close off the free flow of blood from maternal sinuses. Like uterus atony, special use of oxytocics, packing, and fluids may be necessary.

For sake of completeness, one must mention the rare complication of uterus inversion — perhaps due to developmental defects in uterine support, innervation, or traction of the umbilical cord of an unseparated placenta. Few people see enough of these cases to be an expert on the management, but the general consenses of opinion is to try immediate replacement of the uterus, if possible, in a matter of seconds — not minutes. If unable to do so, vaginal pack and supportive measures for the degree of shock is out of proportion to the blood loss. It has been suggested a spinal anesthetic might relieve the present complication and allow correction of position. Curare has also been used in this connection.

Like so many things in medicine, one finds wide variation in the time allowed for the placenta to be expressed before manual removal — that is, providing there is no excessive blood loss. Several authorities suggest a period of one hour, but in any event, the patient must not be allowed to leave the birth room with the placenta still remaining. The problem of analgesia and anesthesis is ever with us for consideration from different facets; but, it is recognized that very deep or undesirable sedation may contribute to uterine atony or execessive post partum blood loss.

Once again we must consider blood dyscrasias — anemia and unnatural capillary fragility — in cases of unexplained post partum bleeding. One could continue to quote medical literature, repeat the need of different antibiotics, but more important and closer to the scene of action is a

summary of some of the things experienced by our colleagues and ourselves doing our everyday work.

If one were to make a present day study of this problem, there are certain pitfalls and errors that enjoy entirely too much frequency. To begin with, adequate prenatal care, education of lay and professional people alike to the fact that although pregnancy is the only function of the human body to be accompanied by a major blood loss, it still brings the patient many times close to the brink of serious trouble. As for the obstetrician, he should and must see his patient frequent enough and give enough service to the patient to establish her obstetrical capacity; supplementing her exam with radiology, blood examinations, or other indicated procedures in order to catalog the patient for the best plan of delivery, whether it be through the birth canal or by Cesarean Section. If Cesarean Section is indicated then adequate preparation of the patient should include contributory consultation, not just a friend of yours, good safe anesthesia, proficient surgical technique, and begin no procedure without having a needle in the vein for fluid — one of large enough caliber to carry the already properly typed, crossmatched, and Rh classified blood. The use of correct uterine sutures, uterine packing for bleeding sinusoids of low placenta previa, and oxytocics all aim at preventing undesirable post operative blood loss. In other words, when abdominal route of delivery is indicated, be adequately prepared.

For vaginal delivery, we have equal hazards, spontaneous or traumatic injury to the cervix or vagina — too often not thought of and many times completely neglected. It should be a matter or routine to palpate the lower uterine segment, cervix, and vagina after delivery. Prompt repair of lacerations usually heal nicely, and give a good looking and normal functioning feeling cervix. We owe this service to our patients and we have a solemn obligation to demonstrate good obstetrics to young staff physicians because they are the obstetricians of so called tomorrow. Awareness of the possibility of hematoma formation due to a subsurface vulvar varicosity or bleeding vessel in a episiotomy may give rise to a huge dissecting hematoma and shock. Therefore, good repair and inspection of episiotomy before the patient leaves the delivery room is necessary.

Again may I stress the advantage of vaginal exam after delivery especially when forceps have been employed in breech delivery. Many cases of hemorrhage are due to uterine rupture of the lower uterine segment, which if diagnosed and taken care of by probable hysterectomy may save the patient from bleeding to death.

Injudicious use of pituitrin to whip up a tired or atonic uterus during a prolonged labor frequently terminates with post partum hemorrhage, whereas, a little sedation such as morphine sulphate or demerol and some fluids will help the patient to regain some of her strength and frequently start off spontaneously with good labor. Here many times the doctor feels he has to do something because of inconvenience to himself or pressure from the patient or her relatives. If he is unfortunate to have this complication, let him use pituitrin and ergot properly, I. V. fluid, transfusions, uterine pack, and whatever else is indicated. Here a word on the physiology of the uterus and pharmacology of oxytocics may be in order. The normal mechanism is for the uterus to retract and contract the fibers of the lower segment and and cervix, this is aided by the administration of pituitrin given shortly after delivery of the baby. Ergonovine given about twenty minutes later begins action just about the time the pituitrin is wearing off. Now, if ergonovine is given first, it may produce contraction of the fundus, but not the retraction and contraction of the lower segment with result you may have the problem of a tonically contracted uterus, a flabby cervix with bleeding sinusoids. Furthermore, if the uterus stays flabby, you may arrest some of the blood loss by pushing up on the uterus from the vagina and pulling up on the fundus with your abdominal hand — thereby, putting the broad ligament on a stretch and partially constricting the uterine artery. The injection of pituitrin directly through the abdominal wall into the uterus has been advocated by some.

When the placenta has been expressed, examine it to make sure of it being intact. Careful exploration of the uterine cavity properly done to remove any detached pieces is far better than permitting the patient to leave the delivery room to go to her room to bleed later on. With modern technique, antibiotics, the risk of infection from a well executed intra uterine examination is far less risky than shock and possible death from

hemorrhage. Here again a word of caution is indicated. There is a dangerous vogue of management of the recently delivered patient. Instead of permitting her to partially stabilize after delivery and making sure of her safety, there is a tendency to wrestle the patient, put on perineal napkins, get her on a stretcher and shove her down the hall in a matter of minutes and the obstetrician be out the door by the time the father learns the weight of the baby. We must make improvement in the management of the so called "4th stage of labor". In large teaching institutions, internes sit with the patient for one hour observing blood pressure, pulse, bleeding, and condition of the fundus. However, most of us do not enjoy such elaborate personnel. This matter is one for each individual M. D. and the obstetrical committee of the several hospitals to have the patient observed by some responsible person for one hour post partum or longer is needed as a so called recovery period.

In summation, it might be stated, hemorrhage is our number one maternal killer. Give your patient adequate prenatal care. Clean up vaginal infection, because if neglected, it may cause premature digestion of suture material with resultant bleeding and hemorrhage. Accurately establish the patient's capacity. Execute all operative procedures with maximum safety including blood, fluid, pack, and proper anesthesia. Routinely examine all cervices before and after delivery and institute better practical management of the patient after delivery. Use enough blood of the right kind soon enough when indicated. Give Ringers Solution between transfusions to prevent renal complications. Don't hesitate to properly pack a uterus or vagina for bleeding. Don't subscribe to paralyzing analgesics or anesthetics. Don't forget, an episiotomy may bleed as late as the seventh day. Don't use vitamin K, digifolin, penicillin, and all the other drugs you can think of to cover up poor obstetrics, faulty technique, or personal inadequacy to deal with this dreaded complication of hemorrhage. Don't be too proud to call for consultation of a worthwhile nature soon enough to do your patient some good, not when she is cold, almost pulseless and bled out. Let's strive to do good obstetrics, not dramatic or primitive obstetrics. It is far better to strive for prevention of this complication rather than carelessly contributing to its production.

SCHOOL HEALTH (Continued)

mean that there is no overlapping of responsibilities. The school has an obligation to help make health services worthwhile educational experiences for children. Likewise, medical, dental and nursing personnel can make important contributions to health instruction. In general, however, the chief task of education can be broadly defined as teaching, that of public health as preventing disease and protecting community health and that of the medical and dental professions as providing diagnosis and treatment.

Practical Office Gynecology

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By the proper use of recent advances in diagnostic and surgical procedures, many problems in gynecology can now be more readily handled in the office or out-patient clinic.

Electrocauterization of the Cervix.—Chronic cervicitis, with its oft accompanying erosions, Nabothian cysts, ectropions, etc., responds very well to electrocauterization. A simple nasal-tip type is used. The following factors lead to satisfactory results:

(1) Optimum time for cautery is midcycle.

(2) Avoid cauterization if acute or of subacute cervicitis is present.

(3) Degree of heat should be dull cherry red in ordinary room light.

(4) 'Cold' cautery is used, i.e. dipped in cold water before inserting into the vagina, to avoid possible vaginal wall burns.

The canal is cauterized circularly or at 12, 6, 3, and 9 o'clock and then the eroded surfaces are touched up. Canal cautery is all-important for it will destroy the diseased glands and epithelium, and thus prevent the out-growth of the endocervical epithelium and its resultant ectropion. Nabothian cysts are punctured with hot tip. Usually no bleeding occurs, and no tampon is used.

The patient returns to the office weekly for about four to six weeks to assure post-cautery patency. A simple cotton applicator or probe dilation of the cervical canal is performed at each visit. It takes about ten to twelve weeks for complete healing. Recauterization is rarely necessary and should not be done prior to three or four months. We have seen chronic recurrent trigonitis respond well to cervical cauterization, apparently because the infected seat in the cervix will exacerbate an already existing trigonitis.

Early Detection of Pelvic Malignancy.—Since carcinoma of the uterus, especially of the cervix ranks as one of the foremost sites for carcinoma in the female, its early detection has been sought for years. To this end we have availed ourselves of cytology and biopsy almost as routine procedure.

Cytology.—If we remember that the endothelial and epithelial layers of the corpus and cervix characteristically exfoliate, we will at once understand the outstanding work of Papanicolaou. Cells found at the os or in the posterior fornix can be gathered, stained and studied microscopically.

Most carcinomas of the uterus are cervical, (8 to 1) corporal and arise mainly at the squamocolumnar junction. If the cervix be directly smeared or scraped a cleaner picture of cells will be obtained with the added feature of seeing the abnormal ones in relative greater abundance. This method, of course, also allows the obtaining of material from the endometrium which may have reached the external os.

We feel that the ambulant patient should be routinely smeared for cytological study, using an Ayre spatula, or wooden tongue blade, and with the cervix in direct view, via a dry (lubricant interferes with stain) speculum. A circular sweeping surface smear or scraping of the cervix is made, spread upon two clean slides, and immediately placed into a fixing solution containing equal parts of ether and 95 per cent alcohol alone, or even 70 per cent alcohol can also be used. The following technical details in taking the smear should be noted:

(1) "Write-on" glazed slides are used, and the name of the patient written in pencil, is kept separated from its neighbor in the fixative solution by use of a paper clip fastened on the superior (write-on) end.

(2) Smear should not be too thick.

(3) Blood dilutes the presence of epithelial cells; the "bleeding" cervix should be sponged 'dry' before taking smear.

(4) After remaining in fixative for at least ½ hour, the slides can then be removed and delivered or mailed dry to the laboratory or cytologist for staining and interpretation.

Presented by Dr. M. J. Nechtow, Assistant Professor of Obstetrics and Gynecology, The Chicago Medical School at the Postgraduate Conference, Dixon, Ill., April 17, 1952.

From the Fantus Clinics of the Cook County Hospital, the Chicago Medical School, and the Cook County Graduate School.

Having obtained the material from the os (mucous) the portio and spamocolumnar of the cervix, a screening for carcinoma of the uterus can be carried out. Body carcino, a cells will in most cases (80%) pass the cervical canal and adhere to the sticky mucus plug at the os. (From 10 to 20% of body carcinomas are missed by cytologic methods.) Cervical squamous carcinoma can be directly reached as a rule, by the stroke of the spatula.

It must be stressed that interpretation of the smear must be left in the hands of the man experienced in the reading of these slides.

A negative biopsy in the face of a positive smear read by one qualified in cytologic diagnosis may only require a second biopsy for confirmation. Very often a carcinoma in its early stage is not only grossly unrecognizable on physical examination but missed repeatedly on biopsy. We believe that in the near future greater emphasis will, no doubt, be given to the smears stained cytologically and read by one trained to read them. By such means, preclinical carcinoma often preinvasive carcinoma will be more readily detected and, in turn, adequately treated.

Biopsy.—While it is difficult to biopsy every cervix routinely, we certainly feel that any suspicious cervix should receive benefit of multiple punch biopsy. Also, the positive cytology report, must be checked by biopsy. Three or four sites are punched out. The squamocolumnar junction should be included in the tissue biopsied. Painting the cervix with Lugol's solution will aid in selection areas to be biopsied. The tissue is put into 10% formalin. Biopsy sites are covered by oxycel or gelfoam and then by a dry tampon.

Intractable Pruritus Vulvae.—We have found this annoying chronic, idiopathic condition to respond well to infiltration of zylcaine-(a local anesthetic) in oil. After etiologic conditions such as systemic, kraurosis vulvae, leukoplakia, trichomonas, monilia, or lichenplanus, are ruled out, a so-called intractable pruritis exists. Frequently, these patients have made the rounds to several doctors, dermatologists, radiologists, and even psychiatrists. A patch test is done prior to the injection.

The hair is not shaved, and a simple soap and water cleaning is given.

First, simple intradermal novocaine wheals are made in each corner using procaine.

Using an 18 gauge spinal needle, 10 cc. of the "oil" are injected into each of the labia majora, 5 cc. across the supraclitoric area, and across the rectovaginal septum.

Injections should be subcutaneous, in order to avoid superficial slough. The patient is advised to take a tub bath within two to four hours. Relief is often obtained in several hours, but may take as long as seven to eight weeks. If a reinjection is necessary it is done after a period of three months.

Urethral Caruncle. — Using 1% novacaine periurethral block, electro-cauterization with a fine nasal tip cautery will destroy the everted urethral mucosa and the para-urethral glands. Follow up sitz baths are advised to minimize dysuria. Weekly urethral dilation using a graduated urethral dilator is a very important procedure. Often ascending trigonitis, cystitis, and bladder tenesmus are much relieved after adequate destruction of urethral caruncle.

Condylomata Acuminata.—These soft, multiple warts have responded beautifully to the application of 25% podophyllin. After protecting the adjacent skin and mucous membrane with plain vaseline, or zinc oxide, the podophyllin in a hyrosub base, is then applied. The podophyllin must be washed away in 4 hours. If the irritating podophyllin is left on too long, secondary dermatitis, edema, etc., may occur.

The condyloma shrivel up and disappear in one to two weeks. Most cases require only one treatment. If another is needed, seven to ten days should elapse before application. Podophyllin is not effective on hard warts.

Chronic Pelvic Inflammatory Disease.—This condition best responds to intrapelvic heat given in a persistent manner together with antimicrobial therapy. Thermoflo or Elliot (introvaginal) heat are excellent and are given daily for one hour in the office. A temperature of 115-120 is used and a course often to twenty treatments instituted. Patient is advised to rest in the office for one-half hour after treatment. Several courses of treatment may be necessary.

Many pelvics that are "fixed" or that have "fullness" etc. will improve away under such treatment. Chronic sterility and infertility, etc., have been known to respond dramatically with an occasional conception and delivery. It must be cautioned that patients should not be explored

soon after a course of treatment, because the handling of the hyperemic pelvic organs may lead to peritonitis.

For those patients who cannot take treatments in the office, we have been using an "Intrapelvic Hydrothermy apparatus" that can be used by simply attaching it to the bathtub faucet. By means of a two-way flexible rubber hose mechanism, the hot and cold water blended to a suitable temperature will reach the vagina and inflate the intravaginal flexible rubber bag section. The modified intrapelvic heat is taken daily in a reclining position with the bathtub partially filled with warm water, and best given for one hour.

Chronic Skeneitis.—Often a chronic intractable inflammation of the Skene's glands exists. This is best eradicated by thorough electrocauterization of these glands. Anesthesia is obtained by periurethral novocaine block. The pouting duct is strung up over a curved surgical needle, piercing the urethral lumen. A fine nasal tip cautery is employed using a dull cherry-red heat. Weekly post cautery dilations are carried out.

Vaginal Fissure.—This is a most annoying and painful condition in the elderly patient with senile vaginitis. The use of subcutaneous injections of Zylcaine in oil has allowed for healing in some instances by eliminating the associated spasm. Electro-cauterization of these fissures may then be carried out, if deemed necessary. Supportive therapy with 1 mg. Stilbestrol, will aid in cornification, healing and resistance to infection.

Cervical Polyp.—Many cervical polyps arising from the endocervix are readily removed by simple evulsion, followed by electro-cauterization of base and cervical canal. The latter assures hemostasis and provides adequate therapy to the oft-associated chronic endocervicitis.

Care must be taken to determine if the polyp has more than one stalk. Routine alertness for malignancy by the use of cytology and biopsy must be emphasized. Polyps removed must be preserved for sectioning.

Pessary.—The pessary is a useful adjunct in the treatment of (1) malposition of the uterus with symptoms, and (2) procidentia occurring in the poor surgical risk patient.

In the first group the retrodisplaced corpus and adnexae with its passive hyperemia and dilated veins is anatomically connected, with the oft pleasant relief of such symptoms as backache, dysmenorrhea, menorrhagea, etc.

Several factors, however, must be present before the pessary is used:

(1) The uterus must not be fixed.

(2) Other causes for backache and menorrhagia are to be ruled out, including orthopedic and genito-urinary etiologies.

The common type of pessary for correction of retro-position of the uterus is the Smith-Hodge type. The Plastic flexible pessary facilitates insertion and removal immensely.

The patient assumes the knee-chest position. A tenaculum is placed on the anterior lip of the cervix, and with a finger in the rectum pushing forward on the fundus and by traction downward and backward on the tenaculum, the corpus will usually be brought forward. The new position can be aided afterwards, bimanually, and the pessary then introduced so that the corpus is cradled.

The pessaries are kept in place for four to six weeks, removed, washed, and re-inserted. A conservative trial period should not be less than therapy. Thermoflo or Elliot (introvaginal) three months. Before surgery proper evaluation of symptoms with and without the pessary should be made.

Cervical Dilation.—We have found the use of pre-ovulatory dilation to be of value in an occasional case of recalcitrant sterility. Such procedures can easily be done in the office or clinic without anesthesia by the gentle use of uterine forceps or by the smaller sized Hegar Dilatator. In cases of dysmenorrhea where cramp-like bearing down contractions are described, and where all organic causes have been eliminated, premenstrual cervical dilation has been of some value.

SUMMARY

(1) "Office Gynecology" can handle many important procedures without hospitalization and unnecessary expense to the patient.

(2) Efficacious treatments of common gynecological problems are reviewed.

(3) Cytology and multiple punch biopsy are stressed, aiming toward early diagnosis of carcinoma of the cervix.

3-o-toloxy 1,2 Propanediol as an Adjunct in the Treatment of Drug Addiction

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Manteno

In a preliminary communication[1] Schlan & Unna reported on the sedative effect of a new compound, 3-o-toloxy 1,2 Propanediol (Tolserol*). The compound was used by the authors in a trial group of 63 psychiatric patients, and it was concluded from the study that it reduced or abolished gross tremor, relieved severe anxiety and calmed hypomanic patients. Two of the patients were drug addicts treated for withdrawal and in these Tolserol appeared to abolish the somatic symptoms of withdrawal. In general, where the drug was effective, relief was prompter than with other types of sedatives. Unlike other sedatives previously used, no hypnotic effect was noted, the sensorium staying clear and patients feeling "closer to normal". The drug is not known to be addictive or habit-forming.

Known and used primarily for its neuromuscular relaxant effect in hyperactive or spastic individuals, Tolserol in addition was credited with a sedative-like or quieting effect by several authors[2, 3, 4]. Dixon and his co-workers[5] used the product clinically as adjunctive treatment for anxiety-tension and depressive states, and Hecker and co-workers[6] reported a definite effect of the drug upon the nervous system which aided in the psychological response and psychotherapy of their patients.

This communication deals with the findings from a study group of 20 drug addicts treated for withdrawal of the addicting drug. Tolserol was employed as adjunctive therapy in an attempt to alleviate or control some of the withdrawal symptoms.

MATERIAL AND METHOD

Type of Patients. All 20 patients were voluntary admissions. They were desirous of recovering from the addiction or at least decrease tolerance to a more economically acceptable level. All were males, 8 of them negroes and 12 whites.

From the Manteno State Hospital.

*Tolserol is supplied through E. R. Squibb & Sons.

Their physical make-up and habits can be seen from the following table:

addicted to morphine	*to heroin*	*to heroin:cocaine**
1	15	4
age range	*weight*	*duration of addiction*
17-62 yrs.	108-170 lbs.	*6* months-28 yrs. (mean length: 6 yrs.)

*cocaine was used irregularly to produce euphoria and in 2 individuals to decrease the heroin induced impotency when sexual demands were made upon them.

With one exception all individuals used the drugs intravenously, the exception taking heroin intravenously but sniffing cocaine.

Psychiatric Evaluation of Patients revealed no apparent common denominator. Most of them refused to cooperate for detailed psychological or psychiatric work-up. The group, with 3 strongly negativistic exceptions, can be described as inadequate personalities with strong dependent needs. In the absence of gratification of these needs there appeared to be a marked threat to the basic sexual orientation of the self. Histories were indicative of poorly crystallized primary identifications with tendencies toward compulsive heterosexual or masculine aggressive activity. This behavior was usually suspended when the patient was stabilized on drugs.

Evaluation of Maintenance Dose of addicting drug was difficult because of 1) the patients' tendency to exaggerate in order to be "treated better", and 2) most of the heroin available to the addicts had been diluted with other soluble material prior to sale.

METHOD OF TREATMENT

The 20 patients were divided into two groups, A and B. Both groups were given methadone in substitution. The initial dose of this varied from 10 to 30 mg. every four hours and depended upon the duration of addiction, amount of drug used, emotional stability, age, weight and general physical condition of the patient.

All of the 20 addicts had received their last self-administered dose of narcotic from 20

minutes to 3 hours prior to admission and none was experiencing withdrawal symptoms when treatment was started.

Group A — Control Group — 8 patients representing

1 addicted to morphine
5 addicted to heroin
2 addicted to heroin plus cocaine

withdrawal of addiction causing drug carried out by substituting methadone in rapidly decreasing doses. Nembutal (0.2 Gm.) was administered before bedtime for 15 days. Methadone was stopped after a period of from 6 to 12 days (average 8 days). The rapidity of decreasing the amount of methadone was individually determined and depended upon the severity of gastro-intestinal symptoms, tension, anxiety, muscle pains, and panic states.

Group B — Adjunctive Tolserol Therapy — 12 patients representing

10 addicted to heroin
2 addicted to heroin plus cocaine

withdrawal of addiction causing drug carried out by substituting methadone in rapidly decreasing amounts. Nembutal (0.2 Gm.) was given before bedtime for 15 days. The adjunctive therapy consisted of 1 Gm. elixir, initially, which was followed by 0.5 Gm. q. 3 hours. Variations of this were adopted as the study progressed such as administering a smaller dose (0.5 Gm. every 4 hours) and substituting capsules after the initial elixir.

In this group the amount of methadone could be more rapidly decreased than in Group A, without the patients' objection, and only enough was given to prevent vomiting.

COMPARISON OF RESULTS

In both groups no serious sequelae were observed. Yawning, lacrymation, rhinorrhea and excessive perspiration were present in group A as well as in group B in equal amounts.

Group A: Tension and anxiety were noted in this group which varied from restlessness to the verbalization of impending death and agitation, and in 2 patients sedative tubs were prescribed. 3 individuals complained of muscle cramps, especially in the back, shoulders, anterior thighs and calf muscles. The degree of insomnia was somewhat more marked in this group than in group B. In part this may be due to the fact that during withdrawal treatment none of the patients was capable of taking part in group activities or maintaining sustained interpersonal relations.

(1 patient developed generalized seizures requiring additional barbiturate and dilantin medication; he was not included for comparison evaluation.)

Group B: There were no panic reactions in this group, and tremor and muscle twitchings were markedly reduced. Subjectively, the patients exhibited less anxiety and tension; no muscle cramps were reported. In addition to the fact that it was possible to withdraw the methadone-Tolserol patients more rapidly than those on methadone alone, these patients complained in general less and were aple to verbalize their feelings. They were able to carry on a more normal existence. Four of them could perform light duties on the ward and could take part in outside occupational therapy. Six of them were able to play cards and maintain interpersonal contacts during withdrawal.

(1 patient in this group developed severe vomiting and diarrhea despite increased doses of methadone. Tolserol was discontinued but this did not effect the severity of the gastro-intestinal symptoms which continued through the sixth day of withdrawal).

General Remarks.—It is our impression that Tolserol can be useful in decreasing some of the symptoms associated with the withdrawal of addictive drugs, most notably tension, anxiety, muscle pain and cramps. It permits a more rapid reduction in the substitution medication. Patients are able to lead a more normal existence, maintaining social contact and carrying out some physical activity. However, Tolserol was found useful only as long as withdrawal symptoms were not actually present when treatment was started.

Gastrointestinal symptoms when exhibited during withdrawal may be aggravated by Tolserol.

The use of the elixir appears preferable in the initial stage of treatment as it was felt that it is much better retained and tends to combat any pre-existing nausea.

SUMMARY

1) 20 drug addicts were treated for withdrawal. Methadone in decreasing amounts was substituted for the addictive drug.

2) 8 patients received methadone alone; 12 were given methadone and Tolserol adjunctive therapy in an attempt to alleviate the withdrawal

symptoms. 1 Gm. every three hours appeared optimal routine but variations to suit the individual may be adapted.

3) It is concluded that patients receiving the adjunctive therapy

a) can be withdrawn more rapidly

b) muscle twitchings, cramps and tremor can be controlled; there is less anxiety

c) patients are able to carry on a more normal existence taking part in group activities and performing light physical duties; insomnia appears decreased

4) This combination treatment is of value only when Tolserol is given early during treatment, before withdrawal symptoms are exhibited.

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CONSULTANTS REPORT ON SURVEY OF ARMY HOSPITALS

"Internships and residencies in Army teaching hospitals compare favorably with similar programs in the best university hospitals in the country," according to a report by Dr. Joseph M. Hayman, who has headed a special survey by members of the Society of Medical Consultants to the Armed Forces.

The survey was conducted in nine of the Army teaching hospitals in the United States by teams that in most instances included an internist, surgeon, and psychiatrist, with experience in teaching. The survey included an appraisal of intern training, residency training, regular hospital staff and the consultants available at each of the hospitals. Both the intern and residency programs were compared with those in university hospitals. Teaching rounds and conferences available in each program were also evaluated. In addition, several features exclusive to each program were given special study.

Dr. Hayman's group examined the regular and consultant staffs at each facility with respect to training, ability and utilization in the program. Dr. Hayman concluded "that the Army Medical Corps has every right to be proud of its internship and residency programs. It is firmly believed that the program should be continued, not only as a source of well qualified officers for the Medical Corps, but as a stimulus to American medicine."

CASE REPORTS



Intussusception

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Although there has been a gradual increase in the rate of recovery in acute intussusception over a period of years, the prognosis remains grave and the mortality still too high. Consequently the disease is important among the serious emergencies encountered by the surgeon, pediatrician and general practitioner.

The syndromic pattern of acute intussusception, particularly in children, has been well established and there is general agreement on the importance of the time element in diagnosis and instituting treatment. However, a survey of the recent literature reveals that although prompt surgery is the most widely advocated method today, there still exists a divergence of thought on methods of treatment. This contention is between nonsurgical treatment of acute intussusception and immediate surgical intervention.

The choice of surgical procedure also poses a highly controversial problem; whether exteriorization and prompt closure, or resection and primary anastomosis offers the least hazardous and most satisfactory results.

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The first case of intussusception reported in the literature appears to be a case, wherein Nuck[1] in 1784, diagnosed intussusception in a woman of fifty years. The patient was subsequently operated upon by an unnamed surgeon under Nuck's direction and recovered.

In 1836, Wilson[2] performed an operation for intussusception on a man about twenty years of age, in which recovery followed long deferred surgical intervention.

In 1871 Ashhurst[3] voiced his disapproval of abdominal section in cases of intussusception. He reversed this decision, however, three years later,[4] stating that he no longer considered surgery wholly unjustifiable in intussusception.

In 1874 Hutchinson[5] performed one of the first successful operations of this kind on a child, a baby of two years.

Mortimer[6] in 1891, regarded surgery as preferable to nonsurgical methods.

In 1912, Koch and Oerum[7] gave a report of 400 cases of intussusception in Danish children. They favored nonoperative methods generally but preferred lateral anastomosis as the surgical procedure of choice. Hipsley[8] in 1918, presented a resume of 51 cases; in 1926 he gave

an analysis of 100 consecutive cases in which he employed the hydrostatic pressure method for acute intussusception;[9] and in 1935 reported on 486 collected cases, some treated by surgery alone and some with a combination of injection and operation.[10]

Retan[11] in 1927, presented his experiences with nonoperative treatment of intussusception and reported successful reductions with barium enema fluoroscopy.

While the early history of intussusception reveals a few advocates of surgical treatment for intussusception, the attitude in those days was one of 'watchful waiting' for gangrene or sphacelation of the intussusception, and treatment was primarily by nonsurgical methods, such as hydrostatic or air pressure, rectal instillations, and barium enema under fluoroscopic control.

Etiology.—It is well known that acute intussusception assumes an almost stereotyped clinical picture; its symptoms acute cramping pain, vomiting, bloody stools and usually a palpable mass. Likewise, most authors are agreed on the striking absence of demonstrable causative factors, as for the most part the patients are asymptomatic prior to the onset of the acute attack.

In an analysis of 95 cases presented by Oberhelman[12] observed at the Cook County Children's Hospital during a 21 year period, no cause was found for the intussusception in 82.1 per cent of the cases; in 17.9 per cent some cause was mentioned, e.g. Meckel's diverticulum 6 times.

Perrin and Lindsay[13] found hyperplasia of relatively large amounts of lymphoid tissue present in the terminal ileum and in the ileocecal valve, which they believed to be of etiologic importance. Ware and Coffey[14] observed ileocecal lymph glands in 14 of their 65 cases.

The present author has also noted occasional enlarged ileocecal lymph glands at operation for intussusception.

Clinical observation has revealed evidence of potential etiologic value — that a pathological sequence of mesenteric adenitis probably follows recent respiratory infection.

Treatment.— In the past twenty-five years, the literature on the subject of intussusception has been extensive, indicating that research and study have been by no means static. Nevertheless the transition in methods of treating this disturbance has been marked by a lack of definite standardization of treatment. Among present day authors, there are those who still adhere to nonsurgical methods for reduction of intussusception. Conversely, however, the more recent writings reveal a tendency to regard intussusception as primarily a surgical emergency and a marked preference for prompt surgical intervention is emphasized. This has been accompanied by an encouraging decrease in the mortality rate, undoubtedly due in great measure to improved modern surgical technic, and the advent of antibiotics and chemotherapy.

Ladd and Gross[15] in 1934, reported on 372 cases of intussusception encountered at the Children's Hospital, Boston. They regarded intussusception as a surgical emergency and stated that it was their practice to perform immediate laparotomy. In all of their series, treatment was by operative reduction, and resection when this method failed.

Kahle[16] basing his opinion on a high mortality rate in a series of 151 cases in which surgery was employed, stated that anastomosis in the presence of intussusception carries as high a death rate as it does in other types of intestinal obstruction.

Oberhelman regards actute intussusception as primarily a surgical emergency, in spite of the success claimed with hydrostatic methods. He recommends the Lahey-Mikulicz[17] technic where the terminal ileum and colon requires resection and prefers a primary end-to-end anastomosis for segmental resections of the ileum alone.

Dennis[18] reported his success with routine resection and primary anastomosis in strangulating obstructions and a preference for primary closed anastomsis as the procedure of choice in acute intussusception.

Ravitch, et al.,[19] believe that hydrostatic pressure under fluoroscopic control is a safer approach than operation and report that in 27 patients treated primarily by barium enema, there were no deaths. In their opinion, hydrostatic pressure under fluoroscopic control in the treatment of intussusception is auxiliary to and not in opposition to surgery.

Mussil[20] advocates immediate surgery. He condemns reduction of intussusception by hydrostatic means or air pressure because of danger of rupture of the bowel. He credits barium

enema under fluoroscopy as having some merit in the ileocecal type but not in the ileoileal variety. He favors lateral anastomosis around the mass in irriducible intussusception.

Gross and Ware[21] prefer surgical intervention to hydrostatic methods or barium enema. However, they discourage lateral anastomosis, preferring exteriorization as the best procedure.

Although spontaneous reduction of intussusception is not infrequent in children, the unusual aspects of one of the author's cases, has prompted its presentation here. The patient, a boy of 12 years, intussuscepted three times, with three spontaneous reductions within a period of 17 days. On the first three occasions there were no physical findings. However, at the fourth seizure a mass was palpable and a right hemicolectomy with a side-to-side anastomosis was immediately performed.

R. W., a white boy aged 12, was admitted to the hosptial on April 13, 1950, complaining of a stomach ache of two weeks' duration. For the past three weeks he had had a cold in the nose and during this period he had a cough; the discharge from his nose was copious, yellow white in color, and there was little expectoration from the cough. There had been no fever during this time. The stomach ache was centered in the middle portion of his upper abdomen; was intermittent in character, lasting for about one hour and occurring about twice a day. Patient felt that the pain was worse after eating. He had experienced frequent nausea, but only one vomiting spell two days before admittance, at which time the vomitus contained undigested food. Patient did not feel better after vomiting. Pain in the abdomen when present was severe in character and did not radiate. Bowel habits during the past two weeks had been normal as to color, consistency and frequency. Appetite had decreased considerably during the past two weeks, partially because of nausea after eating. Patient was admitted to the hospital walking unaided.

Past history of measles, mumps and chicken pox was reported. Tonsillectomy and adenoidectomy had been performed four years previously.

On physical examination the patient appeared well nourished and did not seem acutely ill. There were no physical findings. Temperature, pulse rate and blood pressure were normal.

Blood count was: red blood cells, 4,940,000; white blood cells 6,900; hemoglobin 95%; with a differential count of polymorphonuclear leucocytes 53%; lymphocytes 43%; monocytes 2%; eosinuophils 2%. Stool examination was negative for blood.

The patient was put on complete bed rest, no medication, and a liquid diet. On the evening of the day of admittance, physical findings were the same. There were no complaints. The next day, April 14, the blood findings were: white blood cells 7,250, and a differential count of polymorphonuclear leucocytes 50%, lymphocytes 44%, monocytes 2% and eosinophils 2%. On the evening of April 14, the white blood count was 6,950, and the differential count was polymorphonuclear leucocytes 41%, lymphocytes 55%, and monocytes 4%. Urinalysis was normal during this period. There were no complaints and patient had a normal bowel movement. Physical examination of the abdomen remained negative. Patient was discharged on April 15, on the morning of the third day of hospitalization, at which time the blood count, urinalysis and physical examination of the abdomen were normal.

The patient was seen at home the same day, April 15, eleven hours after discharge, complaining of nausea, vomiting of a recent meal and severe pain in the center of the upper abdomen. Temperature was normal. Physical examination revealed tenderness of the complete upper abdomen, no rebound tenderness, moderate generalized rigidity of the entire abdomen, no masses, no ascites. Bowel sounds were present but slightly diminished. Patient was immediately hospitalized.

On examination at the hospital, abdominal findings were entirely normal; no tenderness, rigidity or masses. Blood findings and urinalysis were normal. The patient was hospitalized for the following twelve days, during which time he experienced two episodes of severe upper abdominal pain, each lasting for about fifteen minutes. The attacks were four days apart. The patient was nauseated but did not vomit. Bowel movements were normal as to frequency, color and consistency. Daily blood counts and urinalyses were normal. Three stool analyses revealed no blood. A complete gastrointestinal x-ray series, with barium meal and barium



Figure 1. Specimen as removed at surgery, showing the intussuscepiens containing the intussusceptum. Intussuscepiens — The portion of the Bowel, in Intussusception, which receives the other portion.

enema were normal on April 24, nine days after admission. A gallbladder visualization test on April 24 was normal. Patient was placed on a soft diet with boiled skimmed milk and eggs. Medication included sulfathiazole, phenobarbital, and belladonna. Patient was discharged on April 27, four days after the last attack of pain in the upper abdomen, feeling perfectly well, with normal physical findings on examination of his abdomen.

The patient was seen again at his home on the morning of April 30, three days after discharge from the hospital. He complained of severe, constant pain in the upper abdomen of four hours' duration, which caused him to double up in bed. He complained of nausea and had vomited six times. The first vomitus contained food and the rest were liquid in character but contained no blood. Physical examination of the abdomen revealed a mass filling the entire right side of the abdomen. The mass was hard, moderately tender and not movable. Tenderness was present over the entire abdomen, and rigidity was generalized. No rebound tenderness was elicited. Bowel sounds were absent over the right half of the abdomen and diminished over the left side. Stool specimen after digital rectal examination was positive for blood. The patient was immediately hospitalized and prepared for surgery.

On the day of surgery, the blood findings were; red blood cells 4,500,000; white blood cells 16,500; hemoglobin 82%, with a differential count of polymorphonuclear leucocytes 85%, lymphocytes 12%, monocytes 2%, and eosinophils 1%. Urinalysis was normal.

Preoperative medication of morphine sulphate grain 1/6 and atropine sulphate grain 1/150 were given. Anesthetic consisted of intravenous Sodium Pentothal 1%, plus Cyclopropane, plus Ether, plus Helium, plus Oxygen, during surgery. Curare 2 cc. intravenously was administered upon inspection of the peritoneal cavity; 100 cc. of 5% glucose in distilled water intravenously; with Caffeine Sodium Benzoate 1 ampul intravenously; Metrazol 2 cc. intravenously, and Coramin 1 ampul intravenously. During surgery 500 cc. of whole blood and 500 cc. of normal saline solution were started.

Operative Technic.— A right rectus incision was made. An intussusception of approximately two and one-half feet of ileum through the ileocecal valve into the cecum and ascending colon was found. When it was determined that reduction of the intussuscepted bowel was impossible, an incision was made in the peritoneal



Figure 2. Reduced specimen, showing gangrenous intussusceptum (ileeum).

reflexion close to the lateral wall of the cecum and ascending colon. The branches of the ileocolic artery and right colic artery were carefully isolated and ligated close to the mesenteric border. The hepatocolic ligament was divided to mobilize the hepatic flexure. The ileum was divided approximately 5 cm. proximal to its entrance in the intussuscepiens. The transverse colon was divided approximately 2 cm. distal to the head of the intussusceptum. The mass was removed. The stumps of the ileum and transverse colon were closed and a lateral anastomosis was performed. Figures 1 and 2.

All blood vessels were ligated with chromic catgut #0. The intestinal closure was performed with chromic catgut #000.

Pathologic findings were gangrenous ileocolitis, intussusception of ileum, with a specimen consisting of ileum, appendix, cecum, and ascending colon. Numerous enlarged lymph glands were noted in the terminal ileum. Microscopic examination of the ileum and colon revealed the mucosa, submucosa and muscularis edematous; in places necrotic and infiltrated with inflammatory cells. Figure 3.

Patient was decompressed for three days with the Levin apparatus. Three whole blood transfusions of 500 cc., each with 500 cc. of normal saline solution were given daily for four days. Antibiotic therapy included Penicillin 400,000 units twice daily and Streptomycin 0.5 Gm. twice daily for six days. Liquids orally were given on the third postoperative day, and patient was allowed up and walking on the sixth day. He was discharged from the hosptial on the sixteenth postoperative day. Patient was kept on a bland diet and gained ten pounds in three months.

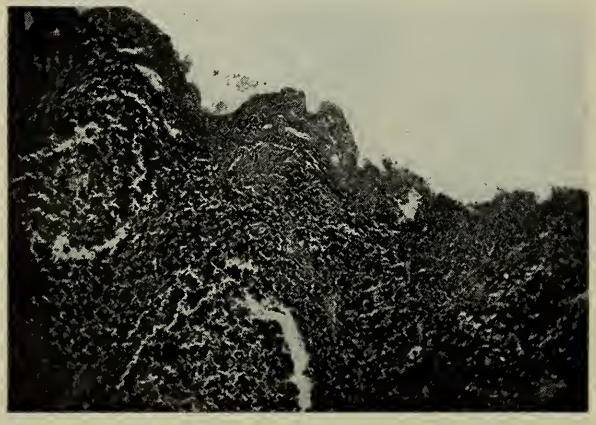


Figure 3. Low power section of ileum, showing mesenteric adenitis.



Figure 4. Barium enema 5 months postoperatively, showing properly functioning anastomosis of ileum to transverse colon.

Barium enema five months postoperatively, demonstrated radiologically a properly functioning anastomosis between the ileum and the transverse colon. Figure 4.

COMMENT

Despite reports in the literature of a definite decline in mortality in intussusception, there still remains much to be desired. In the author's opinion, the greatest influencing factor in success or failure, is the duration of symptoms in the acute type of this disturbance. There is little doubt that a growing emphasis on the part of physicians and surgeons toward prompt action in acute intussusception, is responsible for the improved rate of recovery. This is borne out in a comparison of the death rate over a period of years, with what it is to-day.

The paucity of demonstrable causal factors, retarding to a large degree prompt diagnostic determination in acute intussusception, is an indication for emphasis on further clinical study into the etiology.

The difficulties encountered in diagnosis are illustrated in the author's case, in which there

were no physical findings on three separate attacks. Prompt surgery on the fourth seizure was undoubtedly the primary attributive feature in the patient's recovery.

The particular type of surgical technic is left to the discretion of the attending surgeon. The classical result obtained in the author's case, following a right hemicolectomy with a side-to-side anastomosis, offers evidence of the advantages to and satisfactory results from this type of operation for intussusception.

SUMMARY

1. Controversial opinions still existing regarding the attributes of nonsurgical methods of treatment of intussusception and of surgical intervention are presented.

2. Changing theories in relation to treatment, apparent in the reported literature are discussed. The reports of the past twent-five years show a definite trend toward immediate surgery in acute intussusception, with a concomitant decline in the mortality rate.

3. A dearth of demonstrable causal factors in determining the etiology of intussusception is emphasized, and indicates the need for further clinical study. The importance of etiologic implications of ileocecal lymph glands found at operation, and of the possibility that mesenteric adenitis may follow recent respiratory infection are pointed out.

4. A selected case of the author's is presented, in which three spontaneous reductions of the intussusception occurred in a period of seventeen days. The remarkable character of its onset, phenomenal course, and a properly functioning side-to-side anastomosis between the ileum and transverse colon following a right hemicolectomy are described in detail.

5. An ever increasing recovery rate in intussusception is pointed out and attributed to prompt surgical intervention, transfusions, improved pre- and postoperative care, close attention to fluid and electrolyte balance, and the use of the newer antibiotics and chemotherapy.

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NEWS OF THE STATE



ADAMS

Hospital News.—Dr. Warren Pearce is the new president of the Blessing Hospital staff, Quincy. Other officers include Dr. Newton DuPuy, vice-president, and Dr. Carl Pfeiffer, secretary-treasurer. Officers of the board of trustees who were elected in January have assumed the duties of their respective offices. They are: Kenneth A. Elmore, president, Henry G. Oelklaus, first vice-president, Gifford V. Leece, second vice-president, Charles H. Long, secretary, and Harvey H. Sprick, treasurer. Floyd M. Seaton, the retiring president of the board, served in that capacity for four years, throughout the building of the new addition. New members elected to the board of trustees at the annual meeting of the Corporation held in January include Montgomery Carrott, Parker S. Gates, and Ridgley Pierson.

Staff Election.—The following officers for 1953 are announced for St. Mary's Hospital staff: Dr. M. E. Bitter, president, Dr. E. L. Caddick, vice-president, L. M. Wolfe, D.D.S., secretary-treasurer, Dr. G. Perisho, clinical conference, Dr. F. Mayner, pathological conference, and Dr. F. Brenner, W. Libmann, H. Espey and G. Tourney, executive committee.

Postgraduate Conference.—A Postgraduate Conference was arranged by the Postgraduate Education Committee of the Illinois State Medical Society in cooperation with the staff of Cook County Hospital of Chicago, at the Lincoln-Douglas Hotel, Quincy, March 19. The speakers included in the program were Dr. Arthur Bernstein, "The Treatment of Coronary Heart Disease"; Dr. Frederick Steigmann, "Diagnosis and Management of the Jaundiced Patient"; Dr. William J. Pickett, Vascular Disease of the Extremities"; Dr. Louis P. River, "Diagnosis of Breast Cancer"; Dr. Archibald T. Hoyne, "Poliomyelitis and Hospitalization"; Dr. Jacob E. Reisch, "Medical Organization", and Dr. Arkell M. Vaughn, "Acute Abdominal Emergencies".

Society News.—Dr. Edward Massie, St. Louis, discussed "Cardiac Emergencies and the Evaluation of the Cardiac Patient as an Obstetrical and Surgical Risk" before a recent meeting of the Adams County Medical Society in Quincy.

COOK

Conference on Alcoholism.—The Greater Chicago Industrial Conference on Alcoholism featured a one day meeting, March 13, at the LaSalle Hotel, under the auspices of Portal House of the Chicago Committee on Alcoholism and the Chicago Association of Commerce and Industry. "The Problem of Alcoholism" was the theme of the morning session; "How Industry Meets the Problem of Alcoholism," the luncheon session, and "Meeting the Problem of Alcoholism Through Treatment", the afternoon session.

Society News.—The Chicago Pediatric Society was addressed March 17 on "The Care of the Handicapped Child". Discussants were Dr. Abraham Levinson, Medical Aspects; Dr. Julius B. Richmond, Emotional Aspects; Mary E. Courtenay, Special Education; Dr. Edward Press, Social Agencies; Dr. William G. Fox, Institutions and Jane Shover, The National Society for Crippled Children and Adults.

Dr. Howard Sloan Memorial Research Grant.—Friends of the late Dr. Howard Sloan have instituted a research grant in his memory to be perpetuated to the extent of $500 per year for the bene-

fit of the Department of Physiology of The Chicago Medical School, according to an announcement by President John J. Sheinin. The grant is to be known as the Dr. Howard Sloan Memorial Research Grant. Dr. Sloan, an alumnus of The Chicago Medical School, died June 15, 1952. He served at one time as Student Health Officer at the School and did research as a Fellow in the Department of Physiology. At the time of his death he was on leave for graduate work at the University of Chicago Medical School.

The Hedblom Lecture.—Dr. Duff S. Allen, professor of surgery, Washington University School of Medicine, St. Louis, delivered the Annual Hedblom Memorial Lecture, March 18, on "The Surgical Treatment of Coronary Occlusion". The lecture is presented under auspices of Iota of Phi Beta Pi.

Northwestern Luncheon.—The Northwestern University Medical Alumni luncheon will be held in New York, Thursday, June 4, at 12:30 at the Waldorf-Astoria Hotel (Jansen Suite). The cost per plate will be $6.00. Principal speaker will be Dr. Richard H. Young, Dean, of Northwestern University Medical School. Reservations should be made at the Medical Alumni Office, 303 E. Chicago Avenue, Chicago 11, or at the Registration Booth, American Medical Association headquarters, New York City.

Personal.—Dr. N. J. Kupferberg was chosen president of the Meyer G. Meyerson Foundation for Research in Nephritis recently.—Dr. Emil J. Stein was recently appointed night warden of Cook County Hospital, newspapers reported. The position had been vacant since the death two years ago of Dr. Roger T. Vaughan.—Dr. Maurice Cottle, professor and chairman of the Department of Otolaryngology, Chicago Medical School, gave a course on "Reconstructive Surgery of the External Nasal Pyramid and Nasal Septum" before the Department of Otolaryngology, Washington University School of Medicine, St. Louis, February 28-March 7.

Institute of Medicine Chooses New Officers.—The Institute of Medicine of Chicago announces the election of the following officers for 1953: Lewis J. Pollock, president; Earle B. Fowler, vice president; George H. Coleman, secretary; and E. Lee Strohl, treasurer. Henry T. Ricketts continues as chairman of the Board of Governors. New members of the Board of Governors, elected at the annual meeting of the Institute on December 2, are: John M. Dorsey, Charles W. Freeman, Edwin F. Hirsch, and Vincent J. O'Conor.

Dr. Herold C. Hunt, superintendent of the Chicago Public Schools and Roy J. Gibbons, Science Editor of the Chicago Tribune were made Citizen Fellows of the Institute and Mrs. Frank M. Peters a Benefactor.

Annual Tuberculosis Conference.—"The First Five Years" was the theme of the Fourth Annual Tuberculosis Conference of the Tuberculosis Institute of Chicago at a meeting in the Hotel Sherman, March 19-20. Every phase of tuberculosis care, from that of organization, to the medical, surgical and rehabilitation aspects were covered in the two day meeting.

Lectures About the Country.—Dr. Louis B. Newman, Chief of the Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Hines, Illinois, lectured at the Louisiana State University School of Medicine, New Orleans, February 12, on "Significance of Physical Medicine and Rehabilitation".—Dr. Max Thorek addressed the Regional meeting of the International College of Surgeons at Dallas, Texas, February 7. He discussed "Impending Death Under Anesthesia".—Dr. Meyer Solomon addressed a joint meeting of the Mexican Society for Neurology and Psychiatry and the Mexican League for Mental Health, recently, on "Emotional Depressions—Early Recognition and Management".—Dr. Meyer A. Perlstein, Chief of the Children's Neurology Clinic, Cook County Hospital, presented a Cerebral Palsy Clinic for the Crippled Children's School in Jamestown, North Dakota, recently, for which he is Medical Advisor.—Dr. Otto L. Bettag, recently appointed Welfare Director of Illinois, addressed the Rocky Mountain Chapter of the American College of Chest Physicians in Denver recently on "Cancer Detection in Large City Tuberculosis Surveys".—Dr. Jules Masserman, Professor of Nervous and Mental Diseases, Northwestern University Medical School, lectured recently to the Mexican Neuropsychiatric Society and the Psychiatric Corps of the Mexican Army.

MACON

Society News.—The Macon County Medical Society held a Dry Clinic and presented cases, February 24, at a meeting at the St. Nicholas Hotel. The subject was "Problems and Management of Diabetes". In the evening, Dr. Cyril K. McBryde, professor of medicine, Washington University School of Medicine, discussed "Management of Thyrotoxicosis".

Expansion of Bulletin Planned.—The Macon County Medical Society plans to expand its bulletin to circulate among nine other counties of the 7th District. Tentatively, it is planned to change the title of the bulletin to 7th District Medical Bulletin. The following counties make up the 7th District of the Illinois State Medical Society: Clay, Bond, Effingham, Fayette, Marion, Moultrie, Piatt, Shelby and Christian. The change will approximately double the present circulation of the bulletin and each month sections will be run giving news from each of the other counties. Members of the various county societies will be appointed as contributing editors and will be responsible for forwarding news of their county society for publication in the bulletin. According to an editorial announcing the change, in the bulletin of the Macon County Med-

ical Society, the changes will be made on a temporary basis at first to determine if there is enough actual interest in the district to warrant their continuance. This will depend on the cooperation of the various county societies in supplying the bulletin with correct mailing lists and news items.

Personal.—Dr. Hubert Magill, Decatur, was recently ordered to report for active duty in the U. S. Navy. He was to report to the 3rd Marine Division at Camp Pendleton, California, and from there to be shipped to Hawaii.

Society Changes Meeting Date.—The Program Committee of the Macon County Medical Society has decided to change the scientific meeting dates from the fourth Tuesday in each month to the fourth Thursday in the belief that more men from the surrounding towns will be able to attend on Thursday, since this is the usual afternoon they take out of the office. According to the bulletin of the Society, the programs have been set up in advance so that Dr. Edmund F. Foley, professor of medicine, University of Illinois College of Medicine, addressed the Society March 26, on "Medical Aspects of Jaundice". Dr. Ben W. Lichtenstein, professor of neurology at the University, will address the May 28 meeting. The bulletin points out that it is the desire of the Program Committee to present subjects which are of general interest to all and not to engage speakers who are interested in some "narrow phase of medicine or surgery". The Committee urges any members of the Society or physicians in the surrounding towns who attend the Society's sessions and who have suggestions to please submit them to the Program Committee. Members of the Program Committee are Drs. William H. Requarth, Maurice Murfin and George McClure.

MADISON

Society News.—Dr. C. Reed Boles, St. Louis, addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, March 5 on "Problems of the New-Born". At the February meeting of the Society, Dr. George E. Roulhac, St. Louis, gave an illustrated talk on "Subarachnoid Hemorrhage".

VERMILION

Society News.—Dr. Paul S. Rhoads, professor of medicine, Northwestern University Medical School, discussed "The Anti-Bacterial Management of Urinary Tract Infections" before the Vermilion County Medical Society at the Hotel Wolford, Danville, March 3.

GENERAL

"How's Your Health" over WGN-TV.—"How's Your Health", produced by the Educational Committee of the Illinois State Medical Society in association with **WGN-TV,** has presented the following telecasts:

George J. Kidera, medical director, United Air Lines, February 25, on "Planes, Pressure and People". Equipment was provided by the United Air Lines.

M. Edward Davis, Joseph B. DeLee professor of obstetrics and gynecology, University of Chicago School of Medicine, March 16, on "The Expectant Father". Equipment was provided by Chicago Lying-In Hospital.

Theodore R. Van Dellen, assistant dean at Northwestern University Medical School, and Medical Editor of the Chicago Tribune, appeared in all telecasts as moderator.

"Your Doctor Speaks" over FM Station WFJL.—In the radio series "Your Doctor Speaks" over FM Station WFJL, the following physicians appeared in transcribed broadcasts under the auspices of the Educational Committee of the Illinois State Medical Society:

Howard S. Traisman, assistant attending pediatrician, Children's Memorial Hospital, February 26, "Accidents in Children".

Laurence E. Hines, professor of medicine, Northwestern University Medical School, March 5, "Early Diagnosis of Coronary Artery Heart Disease".

Margaret M. Kunde, associate in medicine, Northwestern University Medical School, March 12, on "Obesity—Its Cause, Control and Treatment".

James K. Stack, associate professor of bone and joint surgery, Northwestern University Medical School, March 19, on "Fractures and Casts".

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Frederick Stenn, Park Manor Woman's Club of Chicago, March 17, on "Use and Abuse of 'Miracle' Drugs".

Emerson K. McVey, Parent Teachers Organization of the Esmond School, March 17, on 'Contagious Disease and the School Child".

Sanford A. Franzblau, Woman's Auxiliary of the Northwest Branch of the Chicago Medical Society, March 24, on "Adding Life to Years", and North Center Lions Club, April 7, on "Geriatric Medicine".

Irwin R. Callen, William Penn Nixon PTA, April 14, on "Use of the Newer Antibiotic Drugs in Medicine".

Alfred Flarsheim, Parent Education Discussion Group of Peterson PTA, April 20, on "Emotional Growth of the Child".

Harry M. Hedge, Ingalls Memorial Hospital Women's Auxiliary, May 1, on "Cosmetics: Use and Abuse".

Harry H. Boyle, Bryant School professional meeting, May 6, on "The Health of the School Child".

Eugene L. Slotkowski, National Catholic Kindergarten Association, May 15, on "Mental Hygiene Problems of Childhood".

Edward A. Piszczek, National Catholic Kinder-

garten Association, May 15, on "The Control of Communicable Disease".

Frances P. Gaines, Ph.D., National Catholic Kindergarten Association, May 15, on "Prevention and Correction of Children's Speech Disorders".

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Lawrence Breslow, Chicago, Bureau County Medical Society in Princeton, March 10, on "Infant Feeding and Colic".

Henry Buxbaum, Chicago, Knox County Medical Society in Galesburg, March 19, on "Prolonged Labor".

Jack W. Fischer, Chicago, Kane County Medical Society in Aurora, April 8, on "Congestive Heart Failure: Mechanisms and Treatment".

Eric Oldberg, Chicago, Knox County Medical Society in Galesburg, April 16, on "Use of Contrast Media in Neurological Diagnosis".

Paul K. Anthony, Chicago, LaSalle County Medical Society in LaSalle, May 14, on "Influenzal Meningo-Encephalitis and Its Management".

Willard M. Easton, Peoria, LaSalle County Medical Society in Ottawa, June 11, on "Atlas of Genito-Urinary X-ray Films and External Pathology".

Report on Home and Services for the Blind.—The Department of Public Welfare of the State of Illinois has recently made available its first annual report on Illinois Industrial Home and Services for the Blind, covering the year ended June, 1952. The report is presented under the following divisions: General Philosophy, Field Services—Home Teaching, Group Training Services, Sheltered Employment, Institutional Services and Consultant Services. The report is a philosophical and statistical presentation for the period covered and is available from the Department of Public Welfare.

Field Tests for Water Purification.—Final field tests of a new army mobile water purification unit for military field use were to be made in Illinois beginning the week of February 22, according to Governor William G. Stratton.

The new method of filtration, developed by the U.S. army, will be tested at five different locations through cooperation of the Illinois Department of Public Health.

The unit was unveiled to the public at Lake Springfield during the week of March 8. While at the Springfield site, the army plans to make a 30-minute colored movie of the unit.

Locations and dates of the tests were: Rock Island, Mississippi river, week of February 22; Peoria, Illinois river, week of March 1; Springfield, Lake Springfield, week of March 8; Cairo, Mississippi river, week of March 15; and Cairo, Ohio river, week of March 22.

The locations scheduled are in accordance with the request of army engineers for the various types of water in these rivers and Lake Springfield. The request to make the tests came to the state health department from the Corps of Engineers' research and development laboratories at Fort Belvoir, Virginia. The unit has had some preliminary testing, most recently in the mountains in Utah.

The army asked that the state health department do the bacteriological work for the unit at the various test places, and that it also employ a simplified, time-saving method which has been developed by department technicians.

Standard methods require 24 to 48 hours for bacteriological results. Indications are that the Illinois media gives results in less than six hours.

Annual Election for Society for Medical Research.—Anton J. Carlson, Ph.D., professor emeritus of physiology, University of Chicago School of Medicine, was reelected president. Dr. Maurice Visscher, head of the department of physiology, University of Minnesota School of Medicine, was elected vice-president. The Society voted to give an award in the form of a certificate to Bill Davidson, staff writer for Collier's magazine, for contributions to public health and welfare through scientific articles. The Society announced that a film on the use of animals in medical research is now in production by the Society and will be released shortly.

DEATHS

Tom Finley Beveridge, Chicago, who graduated at Hahnemann Medical College and Hospital, Chicago, in 1917, died January 1, aged 65, of coronary thrombosis and gastric hemorrhage.

Edward V. L. Brown, Winnetka, who graduated at Rush Medical College in 1898, died March 1, aged 76. He was professor of ophthalmology and head of the department at the University of Illinois College of Medicine from 1917 to 1926; professor of ophthalmology at the University of Chicago from 1926 to 1942. At the time of his death he was professor emeritus of ophthalmology at (Rush) University of Illinois College of Medicine.

Alexander W. Burke, Cameron, formerly of Galesburg, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1909, died recently, aged 67.

Thomas James Carmody, retired, Danville, who graduated at the St. Louis School of Medicine in 1907, died July 27, aged 69.

Daniel Thomas Cole, Elgin, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died January 2, aged 70.

Joseph A. Dagnault, Rockford, who graduated at the Chicago College of Medicine and Surgery in 1913, died February 7, aged 68, after an illness of six years. He was a member of the attending staff at St. Anthony's Hospital, Rockford.

Sydney R. Forkosh, Chicago, who graduated at the University of Illinois College of Medicine in 1930, died March 2 aged 46, in Manor Hospital, of which he was superintendent. He was a staff member of the Northwest Home for the Aged.

Donaldo M. Garcia, Bloomington, who graduated at Northwestern University Medical School in 1938, died recently, aged 43.

Nathaniel A. Graves, retired, Kirkland, who graduated at Bennett Medical College, Chicago, in 1890, died February 15, aged 89.

Warner A. Gray, Metropolis, who graduated at The Chicago Medical School in 1933, died February 4, aged 51.

Albert W. Haeffner, Melrose Park, formerly of LaGrange, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died November 4, aged 71.

Richard Herndon, Springfield, who graduated at Rush Medical College in 1914, died recently, aged 63.

Bruce A. Hollister, Elmhurst and West Chicago, who graduated at the University of Chicago, the School of Medicine, in 1932, died March 1, aged 53, as the result of an automobile accident.

Carl C. Lawry, Earlville, who graduated at Northwestern University Medical School in 1903, died recently, aged 76, in Vandalia while enroute home from Texas where he had been spending the winter months.

Vernon E. Lennarson, Waukegan, who graduated at the State University of Iowa College of Medicine, in 1932, died February 28, aged 45. For the last seventeen years he operated the Waukegan Moose lodge clinic and the Barwell Good Fellowship center clinic in Waukegan.

Silas E. McClelland, Decatur, who graduated at Rush Medical College in 1884, died March 8, aged 93. He was chairman of the board of directors of the Millikin National Bank and a member of the James Millikin Estate board of trustees since 1909.

Charles J. Poole, retired, Tucson, (Ariz.) formerly of Mount Vernon, who graduated at Barnes Medical College, St. Louis, in 1900, died in 1950, aged 76.

Garwood C. Richardson, Chicago, who graduated at Northwestern University Medical School in 1922, died March 4, aged 56, in Wesley Memorial Hospital. He was assistant professor of obstetrics and gynecology at Northwestern.

John P. Roark, Chicago, formerly of Bushnell, who graduated at Rush Medical College in 1889, died recently, aged 88.

Frank C. E. Schneider, Peru, who graduated at Homeopathic Medical College of Missouri, St. Louis, in 1909, died recently, aged 78.

Arthur W. Swift, retired, Belvidere, who graduated at Chicago Homeopathic Medical College in 1885, died recently, aged 92.

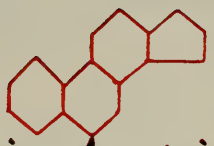
Salvatore A. Vainisi, Chicago, who graduated at Loyola University School of Medicine in 1928, died February 20, aged 49, in Oak Park Hospital.

Clayton S. Whitehead, Naperville, who graduated at Chicago College of Medicine and Surgery in 1913, died in November, aged 73.

In the general hospitals of Canada, the nurse-graduate or student-rarely sees the diagnosed case of tuberculosis, or if a case is diagnosed the patient remains the shortest possible time and is then hustled away to a tuberculosis hospital and forgotten. As a result the student graduates with a very vague knowledge of tuberculosis, its spread, treatment and means of control, unless she has been fortunate enough to have an affiliation in a tuberculosis hospital. Miss Aileen Flett, Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.

The death rate tells only part of the story, that there is still in every community a great reservoir of known and unknown cases of tuberculosis, and that it causes more deaths than any other disease in the age group 15 to 34. Everything points to the need for stepping up the program of case finding throughout the nation and to the need for greatly increased facilities for care of tuberculous persons, but there are now definite signs that the battle against the disease is reaching its final stages. Arthur C. Christie, M.D., J.A.M.A., January 10, 1953.

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



THE TREATMENT OF LUMBAR INTERVERTEBRAL DISK PROTRUSION: AS ASSESSMENT OF CONSERVATIVE MEASURES

R. S. Henderson, F.R.C.S. In BRITISH MEDICAL JOURNAL, No. 4784, p. 597, September 13, 1952.

The diagnosis of intervertebral disk protrusion as a cause of backache and sciatica has become so common that it is important to emphasize the small part that operation plays in the treatment of this disorder. In a disorder with a tendency to natural cure, a patient may receive many different lines of treatment while the natural history of the condition unfolds. The success or failure of such treatment is too often judged on a basis of trial and error. The purpose of this review of 500 unselected cases is to assess, as far as is possible, the results of the various forms of conservative treatment carried out in the orthopedic department of St. Bartholomew's Hospital over five years.

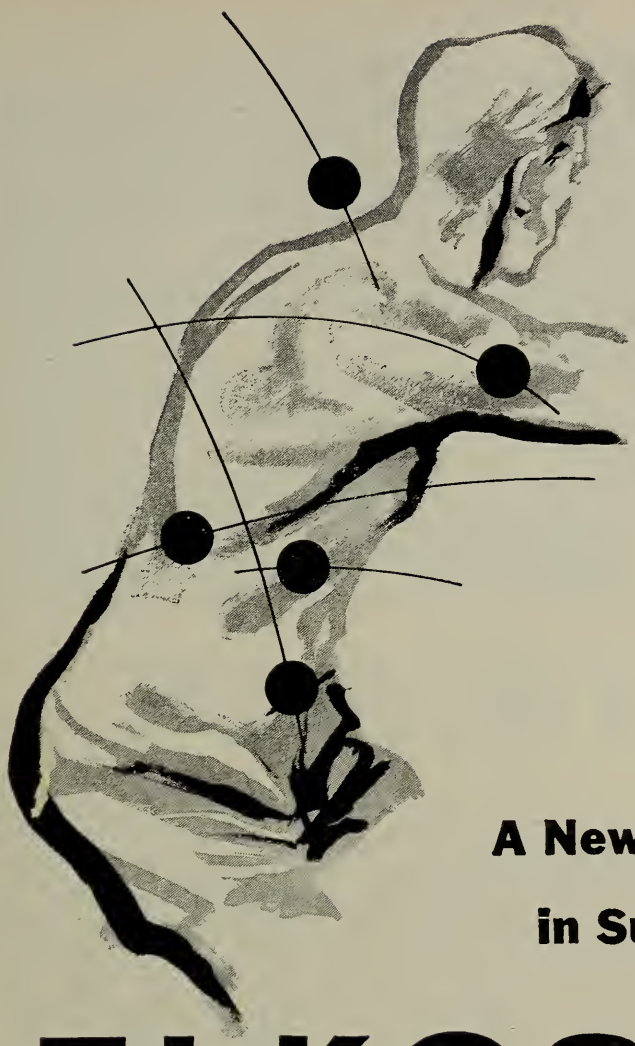
The methods of treatment consisted of bed rest, plaster jackets, lumbo-sacral support, spinal manipulation and extension exercises. Complete rest in bed for at least three weeks, preferably in hospital, was advised when the symptoms were severe or of sudden onset and root tension signs well marked. Plaster jackets were used with those patients who needed bed rest, but for economic reasons could not follow that treatment. Jackets were also used to prolong rest when improvement was slow. Patients were usually fitted with supports when their symptoms were mild and when their lives and work involved activity which made recurrence probable.

Patients treated by manipulation fell into two groups. Of 15 patients with spasm and signs of root tension only three were relieved or improved, and 10 eventually came to operation. Of the second group, those with stiff backs, little root involvement, and a long history of moderately severe symptoms, more than half were relieved or improved. In addition to those recorded as being treated primarily by manipulation in this series, 20 patients were not improved by physical therapy or exercises until after manipulation had been carried out. They had already undergone several other forms of treatment.

It had long been realized that no form of treatment is complete unless exercises to strengthen the extensor muscles of the spine are taught at the same time. In this series, 129 patients with mild symptoms were primarily treated by extension exercises with or without some other form of physical therapy, and over 90 per cent of the patients were improved or relieved without any other treatment.

This investigation has shown that for patients with severe root involvement the correct advice should be complete rest followed by graduated

(*Continued on page* 44)



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exercises. For mild symptoms, early institution of back exercises and physical therapy is probably the right treatment. The majority of cases, however, lie between these extremes, and it is these, with moderate disability, that the decision regarding immobilization is more difficult.

Of the total 500 patients, 406 were initially improved or relieved, and only 58 were considered eventually to require operation. Sixteen were not improved, but were deemed unsuitable for operation because of associated functional disorders. A few were treated by epidural injection, but the number was too small to assess the value of this form of treatment.

DISSEMINATED SCLEROSIS

J. W. Aldren Turner, D.M., F.R.C.P. In BRITISH MEDICAL JOURNAL, No. 4786, p. 715, September 27, 1952.

Disseminated sclerosis is one of the commonest neurological diseases in the United Kingdom and occurs more often in women than in men.

In early cases it is generally advisable not to tell the patient the name of the disease, as "popular" medical books are apt to be consulted and a uniformly gloomy prognosis assumed, which may well be wrong in the individual case. The patient who recovers from an attack of retrobulbar neuritis or a temporary paralysis of a limb who is told that she has disseminated sclerosis, and who then waits for the next attack of the disease and eventual complete disability, when in fact she may have many years of good health or minor incapacity, presents a dismal spectacle. It is usually advisable, however, to explain the situation to a responsible relation and to give warning of the probability of relapses.

The effects of treatment are notoriously difficult to assess in a disease which has spontaneous remissions, but it is generally agreed that no drug treatment known at present has any effect in arresting the course of the disease.

Physical therapy, especially re-educational walking exercises for ataxic patients, is of real help—in particular in reestablishing confidence and in helping them to make the best possible use of their disabled limbs.

Spasticity is a common cause of difficulty in walking in patients in whom reasonably good muscular power remains, but unfortunately it is difficult to influence this.

POSSIBLE HOME CARE IN POLIOMYELITIS

Martin Mills, M.D., Richmond. In CALIFORNIA MEDICINE, 77:1:29, July 1952.

There are three main problems that must be solved to provide adequate home care for poliomyelitis patients: (1) the obtaining of necessary equipment for the patient, such as bed, chairs, hot pack materials, appliances and exercising apparatus; (2) the training of some responsible member of the family in the care that is required for the patient; and (3) the provision of adequate supervision by the physical therapist and the physician.

Greater use should be made of the period of hospitalization to teach and instruct the person who will be the home attendant, in the care of the patient. Too often the mother of the child with poliomyelitis is given no instruction at all or is brought in for a few minutes on the last hospital day, permitted to watch one application of hot packs and perhaps see one physical therapy treatment, and then is expected to continue the same treatment at home. The home attendant works mainly under the supervision of the physical therapist on a definite daily schedule of packs, hot packs, joint motion, exercise, or whatever routine has been ordered by the physician. It is essential that the physical therapist make home visits and treat and teach at the bedside at least at the start of the home care program.

The orthopedic supervision of the patient at home is very important, for problems other than orthopedic problems often arise and should be treated immediately.

In the interests of economy and the welfare of the patient, a well organized system of services for home care of the poliomyelitis patient is essential.

PITFALLS IN THE SURGERY OF THE RUPTURED INTERVERTEBRAL DISK

William Jason Mixter, M.D. In THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, 39:3:159, September 1952.

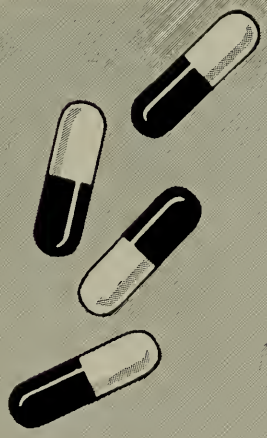
Pain is the outstanding feature in most cases; therefore, do not force operation on an unwilling patient, or without sufficient trial of conservative treatment. A conservative course is based on the probability that the lesion may well be a simple muscle strain, rather than a ruptured disk, and also in the knowledge that in many mild cases

(*Continued on page* 46)

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Also available is Pabirin with Codeine, each capsule containing ¼ gr. of codeine phosphate in addition.

Pabirin gives the arthritic patient what he so urgently seeks—rapid positive relief of the discomfort, with a minimum of side actions. With pain controlled, joint mobility improves and spastic muscles relax. Pabirin produces these outstanding results in arthritis, neuritis, myositis, gouty arthritis, and rheumatic fever.

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of ruptured disk the patient apparently makes a complete recovery following a few days of conservative treatment. If evidence of paralysis is present, however, even though partial, immediate operative intervention should be urged.

The after-care in a case of ruptured intervertebral disk is of great importance. Too often the patient in such a case is carried through the immediate postoperative phase and then dismissed to the family physician without proper follow-up and without proper instruction concerning his future activities. Each patient should be told postoperatively that his spine is not as strong as before it was damaged, whether a fusion has been done or not. He should be cautioned against lifting extraordinarily heavy weights, even after recovery is complete. He should be taught how to lift properly by bending the knees and lifting with the thigh muscles. His back muscles are atrophic and tight. Setting exercises should be started as soon as safe, and later, depending on the individual patient and the type of operation performed, limbering exercises should be added. Swimming is an ideal exercise to strengthen the back muscles. Some patients continue to be perfectly well years after operation, as long as they continue their exercises, but when they give up the exercises, trouble occurs.

THERAPEUTIC APPLICATION OF HEAT: ITS USES AND ABUSES

George Morris Piersol, M.D. In THE NEW ENGLAND JOURNAL OF MEDICINE, 247:10:346, September 4, 1952.

No therapeutic procedure is more commonly employed in either a department of physical medicine and rehabilitation in a general hospital or the home than application of heat in some form. Numerous methods are available for the application of thermal stimuli to living human beings, heat, when it is employed therapeutically, being derived from several sources of energy—radiant, electric or sonic.

In microwave diathermy, which has recently been developed, the physical properties of electromagnetic energy produced in a radar system are utilized to bring about deep localized heating. It brings about a more concentrated heating than short-wave diathermy, as well as a greater penetration of heat. The degree of heating and the depth of heating when this form of energy is applied depend upon the type of director used, the power output employed the distance of the director from the skin and the duration of the treatment. Most observers state that microwave radiation causes a marked increase in blood flow. The greatest rises in temperature were noted in superficial muscles lying about 1.5 cm. beneath the skin, where elevations of temperatures of 2 to 5 degrees C. were observed. It should be noted that when microwave radiation is applied, patients experience a mild sensation of warmth, and it is important to remember that the patient's sensory reactions alone must be used as an index of the amount of dosage. Microwave radiation shares the disadvantage of all methods of heating by high-frequency electrical currents in that there is no method by which the dosage delivered to the patient can be accurately estimated. All forms of diathermy find therapeutic usefulness in conditions that require the application of deep, penetrating heat.

It has long been known that the local application of heat is effective for the relief of pain, particularly that of neuromuscular origin and in arthritic conditions. The relief of pain in acute poliomyelitis by the use of hot packs is another example of this effect. Hot packs, baths and various forms of radiant heat are widely used to bring about general relaxation and relieve muscular spasm. Therefore, heat is frequently applied before massage, manipulation or therapeutic exercises are undertaken. Also, in suitable cases of chronic arthritis appropriate forms of heat are most helpful.

As is true of all effective forms of therapy, however, there are cautions to be considered in the use of heat. Extreme care must be exercised to avoid burning the patient.

In the use of all forms of thermotherapy it is important to remember that there is real danger of bringing about disastrous results if even moderate degrees of heat are locally applied to the extremities of patients suffering from impaired peripheral circulation. Also, the disregard of some of the physiologic changes that occur when heat is used has not infrequently been responsible

(*Continued on page* 48)

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DIETETIC FOODS

boon to the millions whose caloric intake must be reduced

Theoretically it is not difficult to organize a diet which will adequately reduce the caloric intake of the individual so that orderly weight loss occurs. If human beings ate only to satisfy hunger, it would not be so difficult for obese patients to stay on a weight reduction regimen.

Their excessive appetites and the exaggerated importance which eating occupies in their lives may well be related to psychologic aberrations and obscure frustrations. It is this very perversion of the appetite that makes it so difficult for the obese to remain on the reducing diet—so many of the foods prohibited are the very ones that are most pleasurable.

Even on a well-organized high-protein diet, in which hunger is held in complete abeyance, the craving for something sweet becomes more and more intense, and if self-discipline is not sufficiently rigid, "cheating" results.

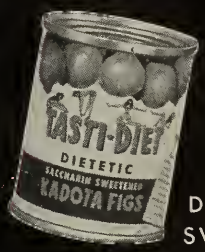
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Tasti-Diet Dietetic Foods—an array of 36 low-calorie fruits, vegetables, salad dressings, puddings, jellies, and gelatin desserts —can make the difference between success and failure in any weight reduction program. Through their use the reducing diet can provide—within the realm of the proper caloric limitation—an abundance of salads with tasty dressings, luscious fruits in a sweet, rich, syrup-like liquid, delicious desserts and jellies that satisfy the craving for sweets.

Physicians are invited to send for literature and a representative sample of each category of the foods mentioned.



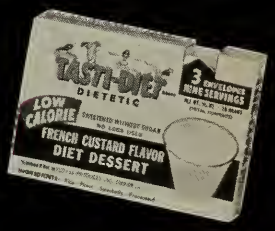
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for disappointing results from and unfavorable criticism of thermotherapy.

EARLY TREATMENT OF INJURIES TO FLEXOR AND EXTENSOR TENDONS OF THE HAND

Herbert v. E. Thatcher, M.D. In NORTHWEST MEDICINE, 51:10:867, October 1952.

The most important single obstacle to healing and function following hand injuries is infection. To prevent this, primary treatment must be carried out as soon as possible after injury, preferably within four hours. To be adequately treated, the patient must be cared for in a hospital and not in the physician's office. Repair of the injury is best done under a general anesthetic and under the same sterile conditions employed for any other surgical procedure.

To prevent formation of adhesions and insure adequate function of the joints as well as adequate function of the tendons in their sheaths, daily finger exercises are started as soon as the initial dressing has been removed. These are at first passive, then gradually more active, and they vary somewhat in accordance with the tendons that have been repaired.

Thus, when flexor tendons alone have been repaired, the patient is asked to flex the fingers a little each day and extend them just to the limit of the semiflexion position maintained by the bandage so that there will be no undue strain on the suture line. At the end of about three weeks there usually is enough physiologic union of the tendons to permit more active daily flexion and extension. The patient is then encouraged to increase his finger exercises until the maximum amount of motion has been obtained.

When only extensor tendons have been repaired, the patient is asked to flex and extend the fingers a few times as soon as his dressing and splints have been removed. Then the splints are applied again. We all know that we cannot leave a splint on a finger continuously for from three to six weeks and achieve a good joint motion, even if the tendons have been sutured. By the third or fourth postoperative visit the patient can be taught how to reapply the splints himself after he has carried out his daily flexion and extension exercises. He must, however, be impressed with the importance of (1) wearing the splints as long as there is any droop of the extensor mechanism and (2) carrying out daily finger exercises during this time. By the end of four weeks splints are usually necessary only at night.

When both the flexor and extensor tendons have been repaired in the same finger, the exercises are the same as they would be if only the flexor tendon had been repaired. In the fingers, flexion is more important than extension. Therefore, every effort must be made to restore the flexion. Extensor tendons can be repaired more easily than flexor tendons at secondary operation.

CARE OF THE HANDICAPPED

Ferdinand F. Schwartz, B.A., B.S., M.D. In PAN AMERICAN MEDICAL WOMAN'S JOURNAL, 59:3:8, March 1952.

Because of the impetus which World War II afforded to physical medicine, the door of hope has been opened to millions of handicapped individuals who were formerly the slaves of pity and charity. The judicious application of exercises, splinting, bracing, vocational guidance, sheltered workshops, occupational therapy, and speech therapy will restore a number of these handicapped to useful membership in the economic life of the nation.

The industrial rate of 87 of the great industrial plants in America, each employing from 5,000 to 12,000 handicapped persons during the last war, showed that the accident rate was not at all bad. Fifty-six per cent found the accident rate of the handicapped to be lower than that of the able-bodied. Forty-two per cent found the rate to be the same as that for the able-bodied, and only two per cent found it to be higher.

The continuing increase in the number of our aged population also poses a problem for physical medicine, which is a valuable adjunct to maintaining their circulatory balance, relieving the pain of muscle spasms and prostatic benign hypertrophies, and keeping their joints mobile.

The large number of hemiplagics in this country also can be greatly benefitted by physical medicine and their progress hastened toward ambulation and self-care. To the millions of patients suffering from arthritis, physical medicine, together with medicinal treatment, will aid in the rehabilitation of these individuals. The prevention of deformity and improvement of the

(*Continued on page* 50)

The *Gentarth* formula constitutes a new, direct approach for relief of pain and reduction of swelling and joint inflammation in rheumatoid arthritis. *Gentarth* is non-hormonal in action.

Sodium gentisate has been found to produce favorable results in both rheumatoid arthritis and acute rheumatic fever,[2] possibly because of its inhibiting effect on the hyaluronidase in synovial cavities.[3,4] Inclusion of salicylate, as in the *Gentarth* formula, provides additional analgesic action and enhances effectiveness.

Gentarth tablets also contain succinic acid to protect against increase in prothrombin time—a necessary precaution in prolonged salicylate therapy.

Each tablet contains:

Sodium Gentisate	100 mg.
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Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

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1. *Boyd, L.J., Lombardi, A.A., and Svigals, C.: New York Med. College Bull.*, 13:*91, 1950.*
2. *Meyer, K. and Ragan, C.: Mod. Concepts of Card. Disp.*, 17:*2, 1948.*
3. *Quick, A.J.: J. Biol. Chem.*, 101:*475, 1933.*
4. *Guerra, J.: J. Pharm. Exper. Ther.*, 87:*1943, 1946.*

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Tablets

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patient's general health are basic principles in the management of arthritics.

The most important part of the physical medicine care of the osteoarthritic individual is in delaying or arresting the progress of the disease by posture. Posture will distribute weight and stress on the joints equally and hence will lessen muscle spasms. Heat, rest and appropriate exercises of course are also necessary in these cases.

Cerebral palsied children also are no longer the "forgotten children." The majority of them can be aided and greatly benefitted with appropriate treatment consisting of physical therapy, speech therapy, socialization, and occupational therapy and education.

ULTRASONIC THERAPY IN THE TREATMENT OF HYPERTROPHIC ARTHRITIS IN ELDERLY PATIENTS

John H. Aldes, M.D., Walter J. Jadeson, Los Angeles. In ANNALS OF WESTERN MEDICINE AND SURGERY, 6:9:545, September 1952.

This investigation of ultrasonics was concerned only with the practical and clinical application of the new procedure. The aim was to relieve pain, and to effect the greatest possible measure of rehabilitation in geriatric patients. Where the authors succeeded, they speak of "improvement." They feel that in order to claim a "cure," they should show permanent relief from symptoms over a longer period of time, which at present they are unable to do. Their evaluation is necessarily subjective, since they had to depend largely upon the statements of their patients.

The objective finding was an increase in range of motion of the affected area. Undoubtedly this was due to ultrasonic therapy with its powerful deep micromassage which increases intracellular metabolism, loosens adhesions, relieves localized congestion, and induces absorption of exudates and precipitates.

Generally, patients reacted favorably to ultrasonic therapy, but relief did not occur until a series of irradiations had been given. It would seem, therefore, that accumulation of irradiation constitutes an important element in eliciting a favorable response.

Although improvement was not obtained in all of the 311 cases treated, none of the patients suffered any negative effects.

It should be emphasized that this is a report on the use of a new procedure for a chronic condition in geriatric patients who had not received relief from previous conservative treatment. The results have been encouraging, but more extensive clinical studies must be carried out before definitive conclusions can be made. However, it seems that ultrasonic radiation may in time become a valuable adjunct to accepted methods of medical therapy in the treatment of arthritis.

MECHANISM OF ABSORPTION OF ULTRASONIC ENERGY IN BLOOD

George Morris Piersol, M.D., Herman P. Schwan, Ph.D., Robert B. Pennell, Ph.D., and Edwin L. Carstensen, M.S. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:327, June 1952.

The investigation of blood and its components has shown that the presence of protein molecules is sufficient to account not only for the entire absorption in blood but also for a significant portion of the absorption in many of the solid tissues. Therefore, it would appear wise, in studying the effects of intense sound on tissue, to give particular attention to the proteins. Wu and Liu in 1931 and Chambers and Flosdorf in 1936 reported coagulation of egg albumin by ultrasonic and sonic vibrations. In both cases this phenomenon was associated with cavitation. It is apparent from the present work, however, that even in the absence of cavitation strong, dissipative forces are exerted on the protein molecules. The mechanisms of the action of ultrasound with and without cavitation should be quite different.

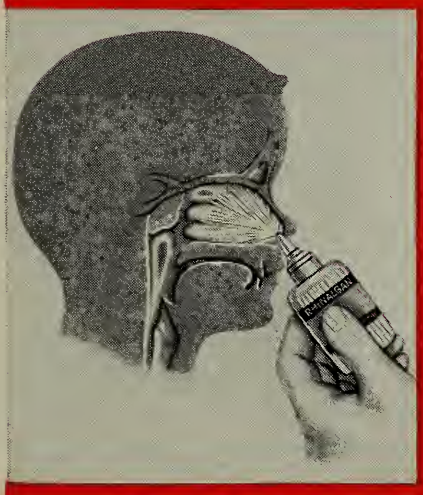
The importance of the proteins in the absorption processes should by no means rule out consideration of structural absorption in the solid tissues. Nelson and others have shown that excess heating does occur at macroscopic interfaces. This investigation, however, has shown that interfaces of the size of the red cell membrane are too small to produce a significant reflection or scattering of waves of the order of one millimeter in length. Therefore, specific effects on cell membranes are not to be expected. More work will be required to determine the pre-

(*Continued on page* 52)

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2. Fox, S. L.: AMA Arch. Otolaryn., 53, 607-609, 1951.
3. Molomut, N., and Harber, A.: N.Y. Phys. 34, 14-18, 1950.
4. Lett, J. E., (Lt. Col. MC-USAF), Research Report, Dept. Otolaryn., USAF School Aviat. Med., 1952.
5. Hamilton, W. F., and Turnbull, F. M.: J. Amer. Pharm Ass'n., No. 7, 378-382, 1950.

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cise conditions under which structural absorption becomes important.

ACCELERATED REHABILITATION IN RHEUMATIC FEVER

Albert J. Simon, M.D., Irving Mack, M.D., and Philip Rosenblum, M.D., Chicago. In AMERICAN JOURNAL OF DISEASES OF CHILDREN, 83:4:454, April 1952.

Herrick House is a year-round convalescent institution for the care and rehabilitation of children recuperating from rheumatic fever. The program at Herrick House differs from that of other institutions in that mobilization is begun as soon as there is clinical and laboratory evidence that the rheumatic process is quiescent. The classic method, as opposed to this, is one of long bed rest, wheelchair, and activity-restricted convalescence.

When it is clinically noted, from observation, examination, and laboratory data that the rheumatic process is quiescent, mobilization is begun. The physical activity of the child is increased slowly, with the result that over a period varying from two to five months, depending upon the rapidity with which he reaches maximum tolerance, the child goes from bed rest with bathroom privileges (called Stage 0) to full activity (Stage 4), which may include rowing, baseball, hikes, swimming, dancing, ice skating, and sledding. Children with severer heart damage and diminished cardiac reserve progress more slowly. Between Stage 0 and Stage 4 there are intermediate stages of graded activity.

The child is advanced through successive stages of physical activity as his condition warrants. Severe heart damage will limit the activity of a few children. These children will reach a plateau of tolerance at the mildly restricted Stage 3 level, and sometimes even at Stage 2. Each patient is given individual attention, and activity tolerance is gauged by an estimate of the child's exercise tolerance correlated with the amount of heart damage. For many patients without evidence of residual heart damage the physician may increase activity by elevating the patient from Stage 1 to 3, or Stage 2 to 4. Thus, the program consists in graded physical activity combined with careful medical observation.

EMPYEMA

T. Holmes Sellers, D.M., M.Ch., F.R.C.S. In BRITISH MEDICAL JOURNAL, No. 4760, p. 704, March 29, 1952.

Many pneumonias are cured by antibiotics; the more pneumonias cured, the fewer the empyemas. However, the distressing picture of an established chronic empyema, with toxaemia, loss of lung function, and a deformed chest, should always be kept in mind as a warning of what may happen if the early stages are not recognized, or are improperly treated.

Even the most efficient treatment by drugs and surgery will be of little value unless at the same time the collapsed lung expands again. The lung must be induced to re-expand, not only to obliterate the empyema space, but to restore pulmonary function. Left to his own inclinations the patient will not move the affected part of the chest more than he can help; the instinct is to immobilize the area. But recovery is complete only when the chest walls are moving freely, and for practical purposes the movement of the chest wall is an index of lung expansion and function. A flattened rigid chest wall is almost certain to conceal an inactive area of lung.

The answer lies in the concentrated application of special breathing exercises which aim at producing a powerful and localized inspiratory excursion over the damaged area. Expiratory exercises, represented by puffing and blowing, should be ignored. The patient is instructed to breathe in deeply and forcibly against the light pressure of the physical therapist's hand without arching or bowing the spine. After a few days he should be able to concentrate the effort in any part of the chest and he must then practice without fail for 10 to 15 minutes every waking hour, with a check once or twice a day by the physical therapist. It is the conscientious patient who benefits and reduces his convalescence to a minimum.

The actual exercises are quite simple, but one must repeat that it is persistence and concentration that count. They are begun almost from the day of diagnosis and are continued with increasing intensity until complete recovery results, with the bad side of the chest moving even

(*Continued on page* 54)

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Physical Medicine (Continued)

better than the normal side. The activities of the patient are encouraged by having him ambulant as soon as the grosser signs of toxaemia have been eliminated. The practice of keeping a patient in bed during the whole period of aspiration or drainage is detrimental to early recovery. During the final stages of closure of the empyema, patients benefit by active exercise, and many of the patients walk 8 to 10 miles a day as part of their convalescent treatment.

THE ELECTROMYOGRAM IN RHEUMATOID ARTHRITIS

Emily E. Mueller, M.S., and Sedgwick Mead, M.D. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:2:67, April 1952.

In the abundant literature on rheumatoid arthritis, many references have been made to the presence of involuntary activity in the muscles of arthritic patients. Trommer states that spasm is the underlying cause of pain and deformities. Schlesinger also attributes certain symptoms of arthritis to muscle spasm. In an electromyographic study, Morrison and associates found the muscles related to the involved joints to be in an inconstant state of tension. Kabat considers spasm to be one of the factors limiting motion even long after the joint inflammation has subsided.

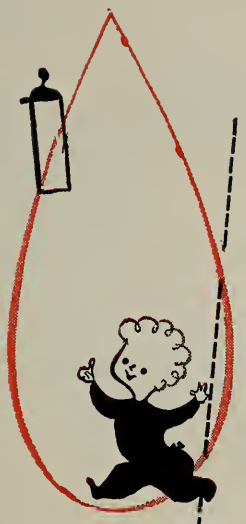
So-called spasm is most marked in the flexors (of the knee joint, for example). Yet the most intense atrophy occurs in the extensors. It is hard to reconcile this paradox with the statement of Fischer that arthritic muscles, or parts of them, are not completely at rest but rather are in a mild state of tonic contracture which enhances atrophy. Harding also suggested that the atrophy, associated with an increased oxygen consumption, is caused by increased activity (abnormal discharge of impulses to the muscles).

The purpose of this study was to determine the electromyographic changes in this disease and to test the theory of muscle spasm as a cause of muscle atrophy.

Mueller and Mead examined twenty-five patients with undoubted rheumatoid arthritis in order to determine their characteristic electromyographic patterns.

In no case could they detect unequivocal evi-

(*Continued on page* 56)



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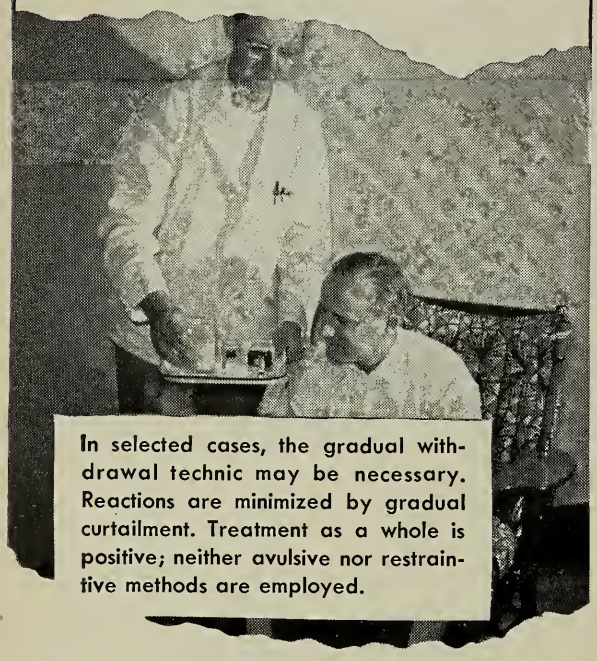
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Physical Medicine (Continued)

dence of muscle spasm or any other type of spontaneous electrical activity.

Some of the records showed tremorous activity and all revealed evidence of weak muscle contractions during voluntary effort.

The results of this study are compatible with the theory that muscle atrophy and weakness in arthritis result from a powerful central inhibitory state in the spinal cord, mediated in some way by painful impulses from the local lesion.

SIMPLIFIED ELECTROTHERAPY: A NEW STIMULATOR FOR HOME TREATMENT OF DENERVATED MUSCLE

Sedgwick Mead, M.D., St. Louis. In ARCHIVES OF PHYSICAL MEDICINE, 33:5:267, May 1952.

This paper points out some of the procedures in which electrotherapy has proved valuable and discusses the basic considerations for a simple, yet effective and intense program of electrotherapy.

Passive muscular exercise forms the greater part of electrotherapy, and often is used where it is not beneficial, while certain fruitful opportunites are neglected. Electrotherapy is a valuable adjunct to the technic of muscle reeducation in early pyramidal tract hemiplegia, in marked alienation (inhibition) from trauma, acute arthritis, local pain, surgical procedures, and to a limited extent in hysteria. However, it is irrational to give passive exercise by electrical stimulation in a situation where return of voluntary control is impossible.

One of the difficulties in the treatment of denervated muscle is the fact that sometimes a year or more is required before reneurotization occurs. Therefore, a simple home treatment program has been designed with two purposes in mind: (1) to maintain the paralytic muscles in optimum nutritional condition for reneurotization and to keep fibrosis and atrophy at a minimum, and (2) to minimize the expense and inconvenience of frequent trips to a department of physical medicine, which is of great importance to patients who live some distance from a treatment center.

The home treatment program requires an electrotherapy unit which, besides providing an adequate wave form for stimulation of denerv-

(*Continued on page* 60)

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ated muscle, must be safe and simple to operate. A model has been designed which automatically delivers direct current in pulses of 0.1 second with an interval of 0.9 second. The internal switching eliminates interrupter keys and simplifies operation for the patient. The model has a single telephone jack plug so that electrode wires cannot be connected incorrectly. The only controls for the patient to operate are the on-and-off switch and the current intensity knob. The ammeter may be omitted, since strength of contraction rather than milliamperage readings is stressed. Safety features include a heavy-duty transformer so that the patient is not directly in the line circuit and has double fuses rated low so that any slight overload in current will break the circuit. Galvanic burns are impossible, and the patient probably will give himself larger shocks than he will endure from someone else because he is in complete control of the instrument and able to stop the treatment at any time.

This device has been used on a limited number of patients with no untoward incidents. However, final evaluation of treatment effectiveness will require several years and a large number of patients.

REHABILITATION TECHNIQUES WITH BRACES AND CRUTCHES: V—TRAVEL TECHNIQUES

Morton Hoberman, M.D., and Erbert F. Cicenia, R.P.T. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:2:82, April 1952.

In order to be truly independent, every disabled person must master travel techniques covering every variety of transportation facility which may be available to him. The degree of emphasis to be placed on traveling activities, especially bus and train steps, in the rehabilitation plan for severely disabled persons is an oft debated problem.

Traveling activities, which are a very important phase of daily living, should be begun as soon as the individual has acquired the necessary strength, balance, coordination, and mastery of

(*Continued on page 62*)



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Physical Medicine (Continued)

basic skills which facilitate the handling of his body efficiently. To meet the travel needs of the individual and to help him get back into normal living, the home and vocational or school situation should be reviewed. Special travel requirements are then set up to simulate contemplated post-hospitalization experiences.

This fifth installment of the article on rehabilitation techniques with braces and crutches presents the methods of performing travel activities used by many individuals with complete or partial paralysis of the lower trunk and both lower extremities. The authors analyze the techniques of opening and closing a wheelchair, getting in and out of an automobile, ascending and descending bus steps, and ascending and descending train steps. Detailed instructions and numerous illustrations are included in this article. The techniques described should be considered as basic methods which can be modified for persons with more involved residual physical disabilities.

THE CONSERVATIVE MANAGEMENT OF CHRONIC RECURRENT LOW BACK PAIN

Charles H. Frantz, M.D., Grand Rapids, Mich. In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, 51:9:1201, September 1952.

Approaching the chronic low back pain problem from a conservative standpoint, it is well to remember that all parts of the body are subject to variations in structure and development. This is particularly true of the lumbosacral joint. There are so many variations at this level that it is sometimes difficult to know what is normal.

A patient with severe muscle spasm should be put to bed. The bed must be firm to support the lower trunk and back, and the knees should be flexed. Sedatives and antispasmodics may be given freely. Local heat in the form of lamps, heating pad or moist hot packs aid in relieving pain and spasm. If physical therapy is available, one may hasten recovery from an acute bout of pain and spasm by the addition of massage. As soon as pain has decreased, exercises may be started, and these should be continued even after the patient is ambulant.

(*Continued on page* 64)

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[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* **90**:96–127, July 1952.



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Physical Medicine (Continued)

There is universal interest in low back pain problems today, and the principles of "rest, heat, and immobilization, followed by postural rehabilitation" are the essentials of a conservative regime. Probably some of us are remiss in failing to instruct patients properly in postural precautions and protective habits. The results of surgical procedures in large series of cases fall significantly short of the 100 per cent cure figure. All practitioners of medicine should offer as complete a conservative program as possible and "carefully" evaluate the patient as well as his back before considering him a surgical candidate.

THE PREVENTION OF DEFORMITIES FOLLOWING THORACOPLASTY

J. D. Murphy, Ila J. Amrhein, Frank P. Ilasi, B. B. Bagby, and W. S. Schwartz. In THE AMERICAN REVIEW OF TUBERCULOSIS, 66:4:436, October 1952.

It is not intended that this article should convey the impression that an exercise program is a treatment for pulmonary tuberculosis. Improvements in anesthesia, surgical techniques, and postoperative care are undoubtedly responsible for the improvement in end results. The authors were convinced, however, that resistive exercises could be used in the early postoperative period without harmful effects upon the pulmonary lesion.

Before beginning this program, it was necessary, in order to prevent criticism, to prove to the physicians concerned with the treatment of pulmonary tuberculosis that the exercises were not harmful. A study was made of a group of 72 consecutive patients who had had thoracoplasties in 1946 (before the initiation of the resistive exercise program) and of 55 patients who were operated upon after adoption of the exercise program in 1948. An evaluation was made one year after the final stage of surgery in both groups. It was found that, in the 1946 nonexercise group, 55.4 per cent had sputum negative for M tuberculosis one year after operation; 71 per cent of the 1948 exercise group, on the other hand, had sputum negative for tubercle bacilli. Complications such as postoperative spreads of disease, atelectasis, and wound infection, as well as the case-mortality rate,

(*Continued on page* 66)

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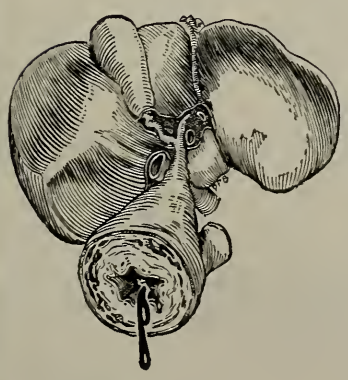
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Physical Medicine (Continued)

were higher in the nonexercise than in the exercise group. In the 1948 study, an evaluation of the immediate effects of exercise was also made. The temperature and the pulse and respiratory rate of each patient were charted before, immediately after, five minutes after, and one hour after exercise. The temperature remained within normal limits at all times. Pulse and respiratory rates were slightly increased immediately after exercise but returned to their original rate within five minutes in every patient. The mental outlook of the patients in the exercise group also was improved.

The authors believe that the primary cause of post-thoracoplasty deformity was the transection of muscle groups and removal of ribs in the operative area. This caused a disturbance in balance of the vertebral column which resulted in scoliosis. The second and minor portion of the deformity problem was the scapulohumeral. The authors believe that the spinal imbalance must be attacked first. Resistive exercises are used to strengthen and re-educate the contralateral muscle groups as the vertebral column is straightened and tensed by active and passive overcorrection. The scapulohumeral phase of the problem is treated by range of motion exercises, resistive exercises for the *Pectoralis minor* muscle, and massage of the scar tissue. The team concept is of the utmost importance in the maintenance of patient morale. Since the adoption of this regimen it has been possible to prevent or minimize postoperative deformity without harmful effect upon the pulmonary lesion.

The program described in this article gives an outline of the plan and, by means of diagrammatic drawings, furnishes the technique of selected exercises used during each postoperative phase.

THE USE OF HYALURONIDASE IN THE TREATMENT OF CHRONIC SKIN ULCERS IN DIFFUSE GENERALIZED SCLERODERMA

Roy J. Popkin, M.D. In ANGIOLOGY, 3:4:325, August 1952.

This is a report on the use of hyeluronidase in the treatment of chronic ulcers of the skin of

(*Continued on page* 68)

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Physical Medicine (Continued)

the extremities in cases of diffuse generalized scleroderma. The ulcers were over the malleoli. They were painful and disabling and of long duration. One patient had received previous treatment consisting of: local therapy as boric acid, aqueous brilliant green solution, aureomycin, terramycin and chloresium ointments and physical therapy (whirlpool and histamine ionization). The other patient previously had received the following treatment: etamon, priscoline and locally, whirlpool, nupercain, chloresium, boric acid, penicillin and sulfathiazol ointments. Both ulcers had been completely resistant to this treatment. On the basis of the favorable response to hyaluronidase applied by iontophoresis in generalized scleroderma, this procedure was adopted in an attempt to cure these two ulcers.

The hyaluronidase was in powder form dissolved in .1 M acetate buffer solution. Asbestos paper soaked with the hyaluronidase buffer solution was placed at the positive pole. At the onset the current was 2 milliamperes for 4 minutes. Within a few treatments, it was advanced to 8 milliamperes for 10 minutes. Iontophoresis treatments were never applied directly to the ulcer.

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Too frequently we fail to realize that health education today stands in the same relation to the control of today's major health hazards as did sanitation and isolation to the control of yesterday's problems. Berwyn F. Mattison, M.D., Am. J. of Pub. Health, Dec., 1952.

Tuberculosis in the diabetic tends to be acute, exudative, and progressive. It shows little tendency to spontaneous fibrosis. The diabetic suffering from such tuberculosis is toxic just as the non-diabetic is with the same type of acute tuberculous disease. David A. Cooper, M.D., and Katharine Boucot, M.D., The American J. of Nursing, Nov. 1952.

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The ultimate aim of any antituberculosis program is the rehabilitation of the patient. Throughout the long days of therapy the patient must be imbued with a belief in his ability to resume a normal life. J. Winthrop Peabody, M.D., The J.A.M.A., December 13, 1952.

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PEPTIC ULCER IN CHILDREN

The etiology of peptic ulcer in infants and children is just as obscure and unsettled as ulcer in adults. Certainly such factors as alcohol, highly seasoned foods, and tobacco which may operate in the adult play no part in the etiology of ulcer in the younger patient. Although worry, mental and physical strain, and so-called tension may not be as important in the etiology of ulcer in the child as in the adult, I am sure it can and does play a part at times. Unpleasant family situations, difficulties with playmates, unpleasant relationships at school, these and other real or imaginary difficulties certainly in some children cause a great deal of worry, tension, and mental strain. Lack of proper rest, diet, and general hygiene lead to some amount of physical deterioration and may be reflected in the instability of the nervous system. In the newborn infant, trauma, vascular accidents, and spasms at the time of birth may be important in the cause of ulcer. In older infants, food stasis has been considered of etiologic importance because the most common site of ulceration is the posterior wall of the stomach and duodenum. Certainly some acute ulcers occur during the course of acute infections, as in the exanthematous diseases, and some of these may be chronic. There may also be an association between the development of ulcers and the onset of hydrochloric acid secretion in the stomach Acid secretion begins at almost the time of birth and reaches a maximum within 48 hours after birth, when it is equivalent to that in an adult. It then begins to fall rapidly and at the end of 10 days reaches the low level at which it remains throughout infancy. Some have thought that the malnourished child is more susceptible to ulcer but it is more likely that malnutrition is the result and not a cause. *Arthur Jenkins, M.D., Peptic Ulcer In Children. Texas J. Med. Nov.* 1952.

With all the additions and improvements in clinical and laboratory procedures, the diagnosis of tuberculosis is more difficult than ever. This is because we have progressed from a stage of making the diagnosis by positive sputum and gross physical signs or marked X-ray changes to a point where the infection is detected when no gross destruction of tissue has taken place. This means negative sputum, no abnormal physical signs, and early changes on the x-ray films. John H. Skavlem, M.D., The W. Va. Med. J., Dec., 1952.

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Mass surveys of the chest are not intended to establish a final diagnosis but to focus attention on persons who show abnormal conditions in order that further study can reveal what the abnormality is and what should be done about it O. Merton Derryberry, M.D., J.A.M.A., January 10, 1953.

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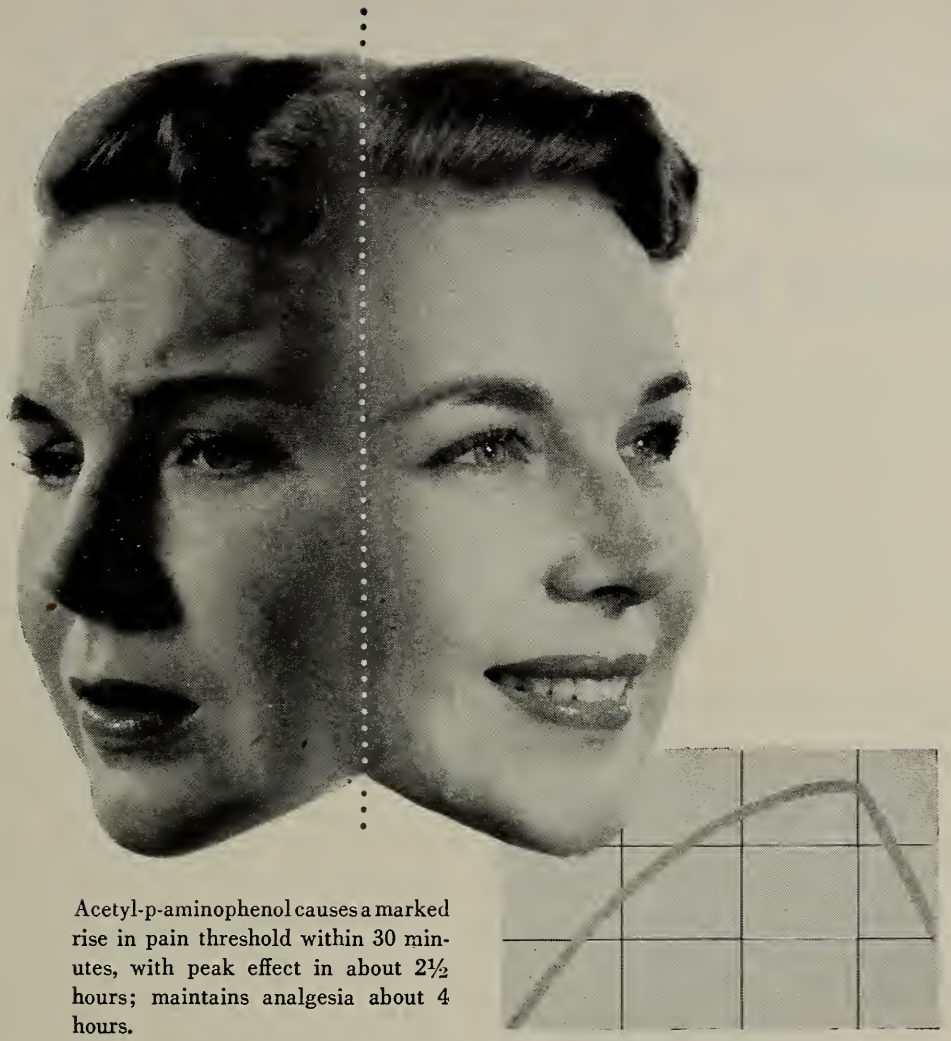
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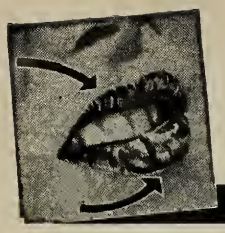
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COLONEL WERGELAND REPORTS ON KOREA

United States troops are getting better medical care than ever before thanks to the effectiveness of the Army's medical training program, Col. Floyd L. Wergeland, Chief of the Education and Training Division, Office of the Army Surgeon General, reported on his return from a recent trip to Korea.

Colonel Wergeland, who visited Korea, Japan and other points in the Far East in company with Maj. Gen. George E. Armstrong, the Army Surgeon General, said that he considered the continuance of the Army educational system, set up prior to World War II for officers and enlisted men, to be among the three fundamental reasons for the success of the Army Medical Corps. The others, in the opinion of Colonel Wergeland, are the high standard of medical education in the United States and the indomitable spirit of the typical American who when presented a challenge follows through regardless of circumstances.

The Chief of the Education and Training Division indicated that the trip made him realize as never before not only the seriousness of the task confronting the Army Medical Service in the Far East but the extent of territory in which it is called to operate.

Reviewing other impressions of the trip Colonel Wergeland commented favorably on the front-line aid, early complete treatment when possible, effective preventive medicine and excellent nursing care available to the U. S. soldier. The efficient medical supply system, combat medical research activities and effective evacuation set-up for the wounded also came in for their share of praise.

Especially notable in the opinion of Colonel Wergeland was the number of highly qualified personnel in combat areas. It is encouraging he said that Corps, Division and Regimental Surgeons are making every effort to keep their aid stations staffed with the best trained enlisted personnel available. With few exceptions every enlisted man assigned to these posts has been fully trained and is being well utilized. Large numbers of men assigned to laboratory duties have had scientific training in civilian educational institutions as well as in the eight-week's course at the Medical Field Service School.

The educational program also is paying off for the nurses, who more and more find reasons for appreciating the training given medical and operating room technicians. Thanks to their training, these medical technician school graduates prove a great help to the nurses in the instruction of less well trained members of their staff.

In carrying out its mission the Army Medical Service must continue to take care of the sick and injured and to support this medical care with the proper kind of training. From what he saw on his trip Colonel Wergeland said in conclusion he was convinced that the system is sound and that the training that it provides is effective.

The ultimate aim of any antituberculosis program is the rehabilitation of the patient. Throughout the long days of therapy the patient must be imbued with a belief in his ability to resume a normal life. J. Winthrop Peabody, M.D., The J.A.M.A., December 13, 1952.

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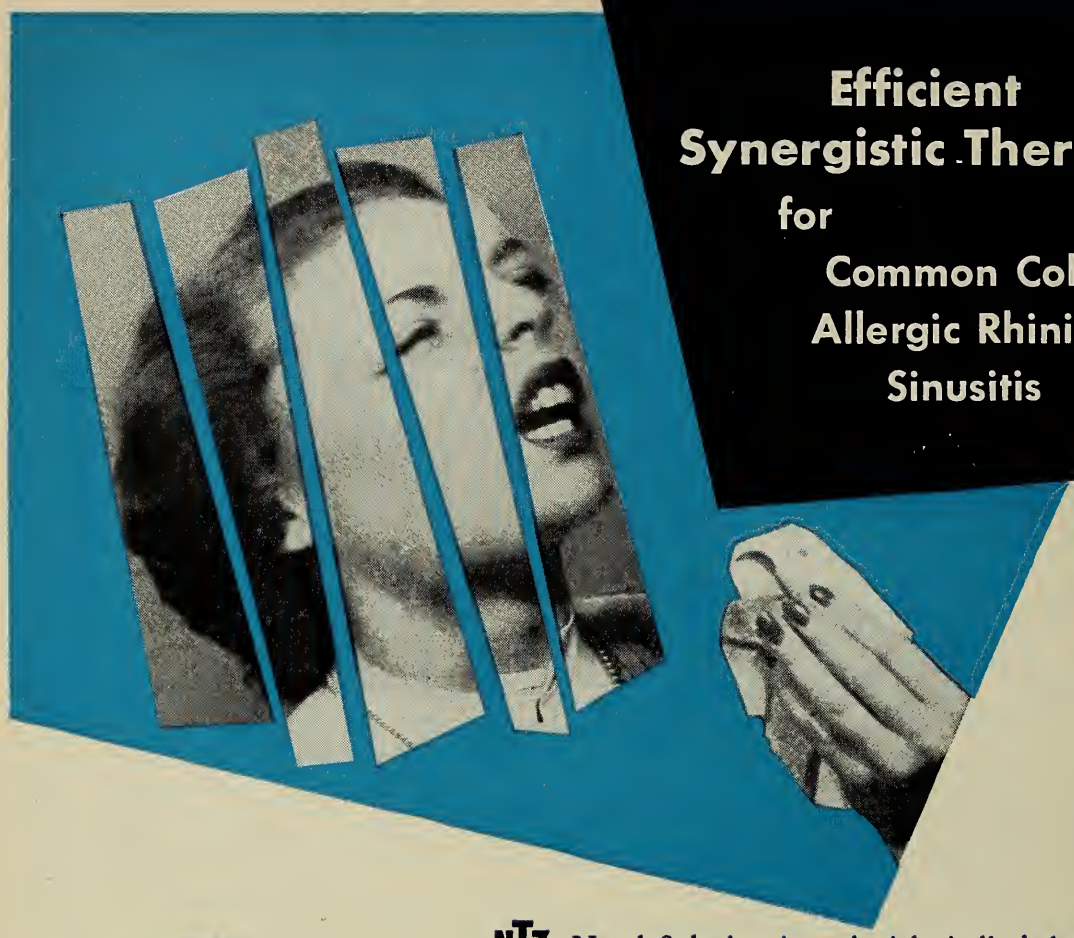
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Vol. 103, No. 5 May, 1953

GAMMA GLOBULIN FOR MEASLES

The demonstration of protection against poliomyelitis by gamma globulin in the studies of Hammon and his co-workers will undoubtedly create a demand for this biologic material beyond any immediate hope of fulfillment. Supplies of gamma globulin from all sources are extremely inadequate to meet what is expected to be an unprecedented demand for the material if it is to be used in the prophylaxis against the three diseases for which a definite usefulness has been shown — measles, infectious hepatitis and poliomyelitis. Certainly the total supply is but an infinitesimal portion of what would be required to protect the entire child population at greatest risk of infection throughout the polio season. The best estimates reveal that available globulin will be sufficient to reduce poliomyelitis incidence by a mere 3% this year, and then only by the most judicious use of the material.

Recognizing the need for equitable distribution of a product which is in short supply, the control of distribution has been placed in the National Office of Defense Mobilization. The American Red Cross is enlarging its Blood Program to meet the demand in part. The National Foundation for Infantile Paralysis has purchased the entire commercial supply and will continue to purchase all future supplies. Both agencies have transferred control of distribution to the O.D.M. and, assisted by panels of experts representing the medical profession and the State health authorities, the O.D.M. is working out the details of distribution for poliomyelitis prophylaxis. The system to be evolved will be predicated upon reporting of clinically diagnosed cases of poliomyelitis and allocations made according to 5-year averages of reported incidence of the disease in the respective states. Emergency and epidemic situations will not be overlooked and a reserve pool will be provided for this purpose. Plans are being completed which will recognize practical methods of distribution for those situations in which the greatest amount of protection will be available for the greatest number within the limits of supply. Such plans will undoubtedly consider susceptible groups at greatest risk for whom the greatest efficiency of protection may be achieved.

Since the value of gamma globulin has been adequately demonstrated in the prophylaxis of measles and infectious hepatitis, the Office of Defense Mobilization has anticipated such needs by setting aside a portion of the available globulin for this purpose. Currently the Illinois Department of Public Health is receiving portions of its allotment for this purpose. Allocations of globulin for measles and infectious hepatitis are based on the 5-year averages of reports of these diseases in the state. To con-

serve the limited supply and provide for judicious use, distribution is limited to intimate susceptible child contacts of the reported case. Full-time city and county health departments, as well as regional offices of the Illinois Department of Public Health, have been provided small supplies of the biologic and physicians may obtain gamma globulin by contacting these agencies directly. Gamma globulin will be released when the physician provides his full-time health department or the regional office with the names of the measles or infectious hepatitis cases and a listing of the intimate child contacts for whom the globulin is intended. Physicians too far removed from any of these offices may request globulin from the Division of Preventive Medicine of the Illinois Department of Public Health in Springfield furnishing the same information required above.

There is every reason to believe that the globulin supply for measles will be adequate if use is limited to proven indications. Gamma globulin has no value in the *treatment* of measles and will *not* be distributed for this purpose. The vast majority (over 90%) of adults have had the disease and have acquired lasting immunity so that globulin will *not* be distributed for prophylaxis in adults. Gamma globulin will probably not alter the course of measles once the disease has set in, so that globulin will *not* be distributed for this purpose.

The most practical application of gamma globulin in measles is for prevention or modification following definite exposure of susceptible children, *provided it is given within the first week of the incubation period.*

Indications for Prevention of Measles:

1. In the very young — under 3 years of age — to obviate bronchopneumonic complications.

2. In older children already ill with other diseases — to prevent further aggravation of the illness by measles.

(Dosage is usually 5 times that required for modification — 0.10 to 0.125 cc per lb. of body weight — early in incubation period.)

Modification of Measles:

1. Children over 3 years of age — to prevent complications.

2. In younger children when administration of globulin for complete prevention cannot be accomplished until late in the incubation period. (Dosage is 0.02 to 0.025 cc per lb. of body weight.)

Modification of the attack does not interfere with the development of lasting immunity. Injection of gamma globulin in preventive doses provides temporary passive immunity only for a period of 4 to 6 weeks.

AILMENTS OF HOUSEWIVES

Housework is the most common occupation of all and the housewife is a frequent visitor to the office of the physician. Her complaints vary but at the head of the list we find backache, tired arms and feet, nervousness, insomnia, varicose veins, and gynecologic disturbances. How often are these symptoms occupational? When they are, can we help by delving carefully into her history to uncover the basic cause?

It might help to know how many hours she spends on her tired feet and whether she has help with the heavy work or does everything herself including floors and windows. Is her kitchen modernized and the tables, sink, and store arranged for maximum efficiency? What about automatic equipment such as dishwashers and washing machines? If she has all the time and labor saving devices, lack of organization may spell the difference between feeling well and below par.

The housewife also has a number of psychic problems that require more attention than merely prescribing a sedative or telling her to "forget it" or "get out of the house more often." It is difficult to control the nervous system when the woman is overworked, fatigued, lonely, or threatened with insecurity. Lack of appreciation is one of the most common basic origins of psychological reactions. This was evident at the Vichy meeting of the Medical Woman's International Association, where a symposium was held on the medical aspects of housework. It was the consensus that housework itself led to no particular symptoms except those concerned with overfatigue, nervous strain, and feelings of inferiority. The Congress suggested better household facilities and education for the job as well as more recreation for homemakers. But above all it stressed the fact that many women believed these factors were less important than was more appreciation for their drudgery. Husbands, please take notice.

A questionnaire was sent out by this group to

women in several countries to compare the living and working conditions of married professional women with those of married women on farms and in textile factories in towns, all of whom had at least two children. We can be proud of our women physicians. They were able to maintain their health even though they averaged 16 hours a week on housework in addition to their practice. They were better organized and budgeted their time efficiently. The report showed also they took better care of their health than the nonprofessionals and their outside work gave them a sense of achievement not obtained by the puttering housewife. The majority in this group had domestic help and much electrical equipment and gadgets to lighten household duties.

DOCTOR, YOUR NAME AND SUBJECTS PLEASE

The Scientific Service Committee of the Illinois State Medical Society has been authorized by the Council to revise the List of Speakers available to county medical societies.

All physicians wishing to be included are urged to send in their names together with a list of the subjects for which they would be available. In instances where physicians are not connected with a teaching position at a medical school, the hospital staff affiliation should be included. Mention should also be made of the type of slide used in talks, and titles of movies if available.

The List of Speakers has not been revised since 1947. In 1950 a mimeographed Supplementary List was assembled, but the Scientific Service Committee hopes to compile a new and timely booklet which will include the advances made in the last few years.

Plans are to enlist the aid of every county society in submitting names of physicians who wish to particpate in the activities of the Scientific Service Committee.

Physicians individually are urged to submit their names directly to Dr. Louis R. Limarzi, Chairman of the Scientific Service Committee, Illinois State Medical Society, 185 North Wabash Avenue, Chicago 1, Room 801.

The need for hospital beds for the tuberculous cannot be reduced but we will see more patients treated in general hospitals. John H. Skavlem, M.D., The W. Va. Med. J., Dec., 1952.

PERTINENT COMMENTS ON THE PRACTICE OF MEDICINE A CENTURY AGO

Dr. David J. Davis, Permanent Medical Historian, Illinois State Medical Society

A concise and lucid statement concerning the status of medical practice of a century ago was written at a time just before the Civil War by a writer of note, a Dr. Nichols who had travelled widely over most of the region of the United States east of the Mississippi River, including the Illini country. (Forty years of American life (1821-1861) by T. L. Nichols, M.D.)

Following is a series of his pertinent comments on the medicine in this region, given in substance or in his own words.

"The medical profession in America bears the evils of haste and irregularity incident to so many of its institutions. It is a country of many and violent diseases. Large portions of the newly settled country, and some of the oldest as well, are full of the malaria that causes intermittent fever. In the West and Southwest there are in swamp and bottom lands worse malaria, causing violent bilious fevers. The cities and villages of the south, unless guarded by rigid quarantine, are subject to yellow fever — the terrible vomito of the West Indies and Mexico. The north, with its cold winters, has multitudes of cases of rheumatism. Childen die in great numbers, in towns of cholera infantum, and everywhere of scarlatina and measles. Continued and typhoid fevers are common.

The Americans, who do everything in a hurry, educate their doctors accordingly. In some states a student is required to read three years under some regular physician and to attend, during this period, two courses of lectures. But if he pays his fees, exhibits a certificate of his study period and passes a hasty examination he receives his Medical Diploma. He has full authority to bleed and blister, set broken bones and cut off limbs. But in most states there is no need of this authorization. Any one may practice medicine who chooses to do so. No diploma is needed and no license required. This is the American idea of "free trade and no monopoly".

There are no medical men as distinguished from Doctors. Also there is no distinction as a rule between Physicians and Surgeons. All

practice medicine, surgery and midwifery. This is necessary in a sparsely settled country. In the large towns a few doctors have adopted a specialty.

Also there are physicians of every school. There are allopaths of every class in allopathy; homeopaths of high and low dilutions; hydropaths, mild and heroic; chronothermalists, Thomsonians, mesmerists, herbalists, Indian doctors, clairvoyants, spiritualists with healing gifts, etc., etc.

The result of so many various systems and nosystems is that thousands of young men are sent out to doctor their unfortunate countrymen; to kill or to cure or it would be safer to say to kill or not to kill according to their good luck, rather than to their science and skill.

This want of any science or established practice in medicine has the natural effect of undermining the confidence of the public in all systems and pathies, leaving them a prey to the most vulgar, mercenary and barefaced quackeries. The consequence is that the shops of druggists and general dealers are filled with quack or so-called patent medicines and nostrums. The newspapers are filled with their advertisements. Fortunes are made by the manufacture of sarsaparilla, pills, catholicons, bitters, cough elixers, cures for consumption, etc. The box of pills that costs a penny is sold for a quarter. The decoction which would be dear at 5 cents sells for a dollar. The consumptives are dosed with preparations of opium and dyspeptics find present relief in bitters whose effects are chiefly attributable to the stimulation of whiskey. One can scarcely conceive of an honorable profession reduced to a lower ebb than that of medicine in the United States.

While medical science is in this chaotic condition in America, hygienic or sanitary science is generally neglected. A thoroughly educated united philanthropic profession, aided by state governments, might do much for health in America."

From time to time it is well for the profession to remind itself of the almost incomprehensible progress made during the past century in medicine; a progress which stands in such amazing contrast to the hodgepodge of theories and practice as set forth above by one of its own members.

Perhaps he was too severe with his colleagues of that-day period, for many of them labored hard and long to improve the science of medicine and to alleviate pain and suffering. Most of them did the best they knew how under the conditions. That is all we can do today. The main difference lies in the fact that we have far more of the "know how" at present.

SOCIETY OF ILLINOIS BACTERIOLOGISTS WILL HONOR DR. SHAUGHNESSEY

The Society of Illinois Bacteriologists, Inc., conferred its sixth annual award for outstanding contributions to the science of bacteriology on Doctor Howard John Shaughnessey, Director of Illinois State Public Health Laboratories, Chicago, Illinois. The award was presented to Doctor Shaughnessey at a meeting of the Society on Saturday, May 16, at the Edgewater Beach Hotel.

Dr. Shaughnessey is well known throughout the United States for his contributions in Bacteriology and Public Health. He was born August 26, 1899 in Northampton, Mass. He was with the A.E.F. in France in 1918-1919. He attended Massachusetts State College and received a B.Sc. degree in 1922. In 1926 Yale conferred a Ph.D. degree on Dr. Shaughnessey. From 1922 to 1926 he was an Instructor in Bacteriology at Yale. In 1927 he became instructor in Bacteriology and Hygiene at the University of Chicago. He also directed research at the University of Chicago on Infantile Paralysis under a grant from the International Commission for the Study of Infantile Paralysis from 1927-1930. From 1927-1929 he directed an investigation of school ventilation in the Chicago area for the New York Commission on Ventilation. He was a National Research Fellow 1926-1927. He became Chief, Division of Laboratories, Illinois State Department of Health in August 1930 until July 1937. From 1931 to 1937 he was also Assistant Professor of Bacteriology and Public Health at the University of Illinois, College of Medicine. In 1937 he accepted an Associate Professorship in Bacteriology and Public Health at the University of Colorado, School of Medicine. He returned in 1938 to Ilinois and from that date to the present time has been Chief and Director of Laboratories, Illinois State Department of

Health, in Chicago. He has also been Professor and Head of the Department of Public Health, University of Illinois, College of Medicine since 1950. On his return to Chicago in 1938 he lectured on Bacteriology and Public Health at Loyola University, School of Medicine, 1938-39, and was Assistant Professor of Bacteriology at Northwestern University Medical School, 1939-1943, and Associate Professor in Bacteriology and Public Health, University of Illinois, College of Medicine 1943-1947 and Professor 1947-1950.

Dr. Shaughnessey is a member of the Medical Advisory Commission, Chicago-Cook County Health Survey and Chairman of the Technical Commission on Preventive Medicine. He is a Fellow of the American Public Health Association and the Chicago Institute of Medicine. He is a member of the Society for Experimental Biology and Medicine and the American Association for the Advancement of Science. Dr. Shaughnessey served as the first Secretary for the Society of Illinois Bacteriologists from 1935 to 1937 and as President from 1946 to 1947. He is a member of the Society of American Bacteriologists and serving as the Councilor from the Illinois Branch 1952-1954. He is a member of the Illinois Public Health Association and an Executive Councilor, he has also served as its Vice-President and Representative to the American Public Health Association. He was Secretary-Treasurer of State and Provincial Public Health Laboratory Directors. He belongs to the Colorado Neurological Society and the Springfield, Illinois Medical Club. He is a member of Phi Kappa Phi, Alpha Sigma Phi and Sigma Xi. He belongs to the City Club and the Yale Club of Chicago.

Dr. Shaughnessey is the author of numerous publications on Bacteriology, Physical Chemistry of Bacteria, Infantile Paralysis and other virus diseases, Public Health Bacteriology and Staphylococcus Food Poisoning.

His home is at 657 Forest Avenue, Glen Ellyn. He married G. Myrtel Heck, Dec. 12, 1919 and is the father of three sons, Howard John Jr., Bruce Arnold and Winslow Morse.

The Society of Illinois Bacteriologists, Inc. is composed of 750 members in the State of Illinois, and includes nearly every professional bacteriologist in the state. It was organized in 1935 as a branch of the national organization known as the Society of American Bacteriologists.

The purpose of the Society's Award is to give public recognition to some bacteriologist residing in the middle west who has made an outstanding contribution to the science of bacteriology. The award was inaugurated in 1948 and will continue to be given once every year in the future.

PUBLIC RELATIONS

In a talk on public relations for lawyers, Judge Julius J. Hoffman made the statement: "You, in your future practice, can do something much more fundamental. The best public relations do not emanate from press releases but from the behavior of individuals. The best public relations man for the legal profession is the honest, intelligent, civic minded lawyer. It is not enough for lawyers to publicize a code of ethics if they violate it or condone violations. It is not enough to cite examples of benefactions and public service if the legal profession does not at the same time make the greatest effort to eradicate abuses and public disservice."

This is good public relations in a nutshell and is as applicable to the medical as to the legal profession. Every individual physician does public relations work every day. What he does or says is either helping or tearing down the profession. Some physicians have grasped the meaning of public relations and act accordingly; others are always walking into traps or do foolish things at the most inopportune times. The actions of a few reek of sabotage. One of the chief arguments against the medical profession is that their charges are too high. Labor organizations are particularly vehement on this point yet at the recent Congress of Industrial Health in Chicago, a CIO labor leader told of a recent experience of two employees in their Denver office. Both had children in need of tonsillectomy and adenoidectomy. One employee who consulted a surgeon about the cost was asked whether he carried health insurance. He said he did and that $60 was allowed for the operation. The surgeon then said: "This is my fee but since you have insurance I'll charge you $20 more." The other union employee saw the same surgeon but informed him that he had no in-

surance. He was charged $60. The employee discovered later that he did have insurance and being honest, told the Denver surgeon of his mistake. He was told: "In the circumstances it will be $20 more."

Only a handful of physicians are guilty of padding the bill but the few make a bad impression. The two instances mentioned, for example, are cited at CIO meetings throughout the country. Most physicians may not realize that health and surgical insurance is devised to help the patient pay his bills. It is a contract between patient and the insurance company, not a method by which the surgeon is justified in charging more. Set the fee and let the insurance take care of itself. If this is not done the very plans that keep us out of socialized medicine — that is, voluntary health insurance — will backfire and may become the wedge that leads us into state medicine.

It is an ironical situation that in these times when we have made more medical advances than in all preceding periods of recorded history, we are witnessing deterioration in the friendly and trusting attitude of the public toward the medical profession. But we should not become too alarmed because suspicion and resentment of authority in almost every field of endeavor is so general. The old order is being changed; everything is subject to question and nothing is sacred. This attitude is noted in the family, in religion, in business, and in government. Apparently it is part of the worldwide attempt to create social reforms.

Many individuals are beginning to classify medical care as an inalienable right along with educational opportunities, food, clothing, and shelter. So far, the medical profession has been able to forestall bureaucrats who advocate compulsory health insurance. The success of this program will depend upon the ability of the medical profession to sell itself to the public.

According to Dr. John T. T. Hundley the public recognizes and resents the following sore spots within the medical profession:

1. Failure to take a personal interest in the patient and his family.

2. The development of professional false pride.

3. A tendency to place an excessive monetary valuation on services rendered by the medical profession.

4. An offtimes selfish interpretation of the principles of medical ethics.

5. Failure to accept as a professional responsibility the acquisition and maintenance of the skill and scientific capabilities of our members.

6. Failure to denounce professionally and discipline the chisellers, the blacksheep, and the dishonest members of our profession.

7. Lip service rather than clear-cut and definite acceptance of the ideal of medicine as a service profession.

These problems cannot be solved by your medical society. They require your personal attention.

THE LAST DAYS OF THE CANCER PATIENT

Dr. Charles S. Cameron, Medical and Scientific Director of the American Cancer Society, reminds us that at any time in this country there are 32,300 persons dying of terminal cancer. These cases are unpredictable and bizarre and present varied problems which are time consuming and not always pleasant. In most instances the patient has not been told the diagnosis and the family is prepared for a long and distressing siege. So far as the family is concerned, "nothing is too good" and the physician can expect — and rightly so -- many unnecessary calls and unusual requests.

According to Dr. Cameron, the attitude of the physician in caring for these sufferers fits into one of the following patterns:

Some physicians are reticent, introverted, and depressed when calling on these patients. This state of mind brings gloom to the profesional team (nurses, technicians, and dietitians) who share in the care of the patient. Others dismiss their lack of interest and resourcefulness by shrugging the shoulders as if to say, "There is nothing I can do and it is unfair of me to come day after day and take your money."

The third type is more kind, sympathetic, and cheerful. He may have little scientific or intellectual interest but tries to make up for his technical inadequacies by relying upon his personality. This is fine while it lasts but most patients with cancer, who find it harder to bear each day, soon conclude that this daily 10 minute interval of optimism and encouragement is hardly enough salve for the remaining 24 hours of

distress. Then there is the stern type of physician who believes in honesty and frankness and feels that the major problems in terminal cancer can be overcome by telling the patient the brutal truth. Such men often do as much harm as good and although there is a growing tendency for physicians to take this attitude, it is difficult to know what is right in the circumstances. Perhaps each patient and each physician is an individual problem along this line.

The more thoughtful, studious physician is ideal. He is considerate and understanding and gives the impression that he wants to visit the patient. He treats each new difficulty as nothing more than a nuisance which needs to be relieved. He is confident he can improve practically any situation until the moment of death and believes that while there is life there is hope. This physician always offers something to smooth out the rough places; he knows eight different ways to make the menus more appetizing and five methods of keeping the patient's room free of odors from fecal drainage. He makes good use of analgesies, narcotics, and hypnotics which offer him a means of counteracting pain for months and months. He favors occupational therapy as a means of converting a dreary, bored existence into a reasonable facsimile of interested, integrated living. He will not give up.

Nowadays physicians have many new palliative agents for pain. Surgical nerve resectioning procedures such as prefrontal lobotomy, chordotomy, rhizotomy, and nerve injections have their place in selected cases. Dependence on morphine is not always necessary because there are a dozen drugs available that can be used in succession and in graded amounts in order to avoid the sledge hammer effect of morphine sulfate. In many instances, pain in cancer is caused by infection which can be controlled with ensuing relief of pain. Radioisotopes, while not living up to the hopes expressed for them five years ago, are the treatment of choice in some malignancies. X-ray therapy also may prove beneficial. The psychiatrist and clergyman give some individuals help which no amount of medical maneuvering can and the physician should offer every encouragement along this line.

MEDICAL SOCIETY ACTIVITIES

The Medical Society of the County of New York is making an attempt to serve better the public, their membership, and medical education. Service to the public includes the Doctors Emergency Service, which has handled many thousands of emergency calls on a 24 hour basis throughout the year. They are geared to deliver a physician in a matter of minutes after receiving a call of distress from their district at any hour. In this way they have overcome effectively the criticism: "You never can get a doctor when you need one." This is only part of the work. They also keep records compiled by the attending physician on diagnosis and disposition of each emergency case so that the family doctor can be supplied with facts he needs to know.

The second phase of this service to the public is the Mediation Committee. Here complaints about medical fees are referred. The Committee was established to protect their membership and the public when controversies arise. They do not fix fees; both sides of the story are heard and the issues are resolved satisfactorily to both. The third phase of their service to the public is the television broadcast, "Here's to Your Health."

The New York group also serves the membership in a variety of ways. It hopes to erase the sordid commercial method of multiple collection agencies by starting a collection agency of its own. This agency will be in keeping with their tradition of dignity and honor and at one stroke will render a service to their members and their patients and obviate much of the bitterness, anger, and resentment engendered by present methods of collection agencies. The group also is working on parking problems for their membership, malpractice insurance, group accident and disability insurance, compensation, basic information on press relations, and the code of professional conduct.

Many other societies would do well to follow the lead of the largest county medical society of the nation.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



V. A. Hospitals and Socialized Medicine

Caesar Portes, M.D.
Chicago

LATEST VETERANS ADMINISTRATION STATISTICS—

October 31, 1952 show the following:

VETERANS IN CIVILIAN LIFE		19,617,000
World War II	15,417,000	
World War I	3,357,000	
Other Wars	843,000	
APPLICANTS ELIGIBLE FOR HOSPITALIZATION (Admission not yet scheduled)		20,569
Disabilities—Service connected	119	
Other	20,450	
V.A. PATIENTS IN HOSPITALS		102,578
In V.A. Hospitals	96,828	
Service Connected	5,750	
NEW HOSPITAL CONSTRUCTION PROGRAM		
New Hospitals completed—through Oct. 31, 1952	45	
New Hospitals in progress—on Oct. 31, 1952	21	
SITE ACQUISITIONS FOR NEW HOSPITALS		
Total Required—October 31, 1952	66	
Sites acquired	66	
HOSPITAL ADDITION AND CONVERSION PROGRAM		
Additions and Conversions completed—through October 31, 1952	44	
Additions and Conversions in progress—on October 31, 1952	9	

What do these statistics mean to you? Don't they have a stigma of Socialized Medicine?

Certainly we are in favor of good medical care for war-wounded, but we are not convinced that the V.A. hospitals have been built only for that purpose.

More than two-thirds of the 102,578 patients in V.A. hospitals today are getting free treatment for non-service connected ailments. Could not many of these pay for their own care? Probably a good proportion of these patients could

pay for their care, but there is no use paying for what can be had for nothing. We know that such free loading of patients in the V.A. hospitals is not limited to veterans in the low-income groups. Many of them are well-to-do business men, professional men, and other substantial people.

The records of the V.A. hospitals indicate that about one out of five patients has voluntary health insurance and many more have accident and health policies that pay the individual directly.

How much of the cost of private hospitalization does such insurance cover? Actually, insurance can pay for an even greater percentage of the cost of private hospitalization; because V.A. care is more expensive than private care. The average stay in a V.A. hospital is much longer than in a local private hospital and V.A. care is much more lavish. Nothing is spared as far as x-rays and laboratory examinations are concerned.

V.A. hospitals are unable to collect from the insurance companies, because a number of them have clauses that exclude benefits for hospitalization in tax-supported institutions. In these cases, the tax-payer is stuck.

We do not object to the hospitalization of those veterans who definitely are unable to pay. If veterans with non-service connected disabilities are indigent, they should be handled by the community — i.e., the city, county, or state — not the Federal Government. Otherwise, fair administration is impossible. But as long as all veterans are taken in, there will not be enough beds for the service connected veterans. Then comes the program of expansion: building new hospitals and increasing the number of beds in the old hospitals. If this program is expanded, it will be an easy way for the Federal Government to take over the medical care of a large segment of the American people. Then it will be too late to yell "Socialized Medicine".

Who pays for this program? You and I as tax-payers. Who loses by this program? We as doctors in private practice.

You and I as doctors are responsible, in part, for this program, for no hospital can exist without doctors. The doctors and the medical schools who participate in this V.A. program are responsible for the creation of this Frankenstein.

The Future of Wisdom in America*

Edwin F. Hirsch, M.D.
Chicago

Learned Hand, one of America's respected jurists, writes that most portions of the Constitution of the United States are specific enough to state their purpose clearly. But a different situation exists in the broad clauses defining the conduct of a free society. Hand poses these questions; what is "freedom of the press", the "establishment of religion and the free exercise thereof", "unreasonable searches", "due process of law" and "equal protection of the law". These specifications are undefined and are not determined without acquaintance with what men in the past have thought and have felt to be their most precious interests. Courts cannot construe controversial questions which are beyond the limits of fair dispute. Accordingly, in such controversies, the voters through their delegates speak finally, and they alone preserve our liberties if they are to be preserved. For guidance, they have no *vade mecums,* handbooks, or manuals but must depend upon enlightenment from within and their conscience. That enlightenment and that conscience, says Hand, must bal-

*The Saturday Review of Literature, page 29, November 22, 1952.

ance every conflicting interest with as detached a temper as is possible.

A law of any kind is at once a prophecy and a choice: a prophecy because it attempts to forecast what will be its effects; a choice, because there is involved a balance between the group interests whose conflict the measure attempts to adjust. Desires and values, the elements of group interests, cannot be quantitated because they seldom have common constituents. It is not enough to be personally detached. We need a capacity for an informed sympathy with and an understanding of the desires and the values of others. That, says Hand, only those may attain whose experience is supplemented by acquaintance with what others have thought and felt in circumstances as nearly comparable as is possible.

An education which includes the "humanities" is essential to political wisdom. By humanities, Hand means history, but close beside are letters, poetry, philosophy, the plastic arts, and music. Most issues that mankind set out to settle are never settled because they are concerned with incommensurables. The dispute disappears because it is replaced by some compromise. He who would find the substitute needs an endowment rich in experiences which make the heart generous and provide his mind with an understanding of the hearts of others. Franklin's letter, written the day before the Constitution was signed, mentioned how an assembly of men, gathered for the advantage of their joint wisdom inevitably assembled all of their prejudices, their passions, their errors of opinion, their local interests, and their selfish views. Yet, Franklin consented to this Constitution because he expected no better, and was not sure that it was not the best.

Hand comments that out of such a temper alone can come any political success which will not leave behind rancor and vindictiveness sufficient to destroy the benefits of a victory. As in science we advance by taking over what we inherit, so in statecraft no generation begins anew. The imagination, he says, can be purged and judgment ripened only by an awareness of the slow wayward course, in failures and in successes, of human life, but with an indominatable will to endure. Albert Schweitzer has said that the most fundamental concept of the human life is the will to live. Hesitancy to act until all the facts are assembled can be serious. Hand chooses rather that some traitors will escape detection than that a spirit of general suspicion and distrust be spread which accepts rumor and gossip in place of undismayed and unintimidated inquiry. A community is in process of dissolution where each man considers his neighbor a possible enemy; where non-conformity with accepted creed is disaffection; where false denunciation takes the place of evidence; where orthodoxy chokes off dissent; and where faith in the supremacy of reason is so timid that no one dares to express a conviction. Mutual confidence can be maintained only by an open mind and free discussion. Then in a long quotation, Hand bids us listen to ancient words telling of the excellence of wisdom, summarized in the brief sentence "for she knoweth all things and hath understanding thereof; and in my doings she shall guide me in the way of soberness, and she will guard me in her glory".

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR JUNE

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the June schedule of clinics for physically handicapped children. The Division will count 11 general clinics providing diagnostic orthopedic, pediatric speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The June clinics are:

June 3 — Hinsdale, Hinsdale Sanitarium
June 3 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Avenue
June 4 — Fairfield, Fairfield Memorial Hospital
June 4 — Litchfield, St. Francis Hospital
June 9 — East St. Louis, Christian Welfare Hospital
June 9 — Peoria, St. Francis Hospital
June 10 — Elgin, Sherman Hospital
June 11 — Elmhurst (Rheumatic Fever) — Memorial Hospital of DuPage County
June 11 — Springfield, St. John's Hospital
June 12 — Chicago Heights (Rheumatic Fever), St. James Hospital
June 17 — Chicago Heights, St. James Hospital
June 18 — Rockford, St. Anthony's Hospital
June 23 — Peoria, St. Francis Hospital
June 24 — Springfield (Cerebral Palsy), Memorial Hospital
June 25 — Bloomington, St. Joseph's Hospital
June 26 — Chicago Heights (Rheumatic Fever), St. James Hospital
June 30 — Effingham (Rheumatic Fever), Douglas Township Building

FOSTER PARENTS

Children born during the war are now from eight to twelve years old. War orphans everywhere have reached an age at which they must recognize what has been done to them and wonder what their future can possibly hold.

Many people have come to realize that money alone is not enough to provide for the needs of cheerless children abroad; that mass relief, which is important indeed, must be supplemented by relief for children on a personal level. With this objective in mind the Foster Parents' Plan For War Children, Inc. has been organized.

The Plan, familiar with each child's specific problems, mediates his "adoption" by a Foster Parent in the United States. No legal steps are required: adoption implies a financial responsibility for fifteen dollars a month — a contribution which is deductible from your income tax. Each child, treated as an individual, receives food, clothing, shelter, education and medical care according to his/her needs.

The children are told of their Foster Parents and correspondence through the office of The Plan (55 West 42nd Street, New York 36, N. Y.) is encouraged. The Plan is a non-sectarian, non-profit, non-political, independent relief organization, helping children in Greece, France, Belgium, Italy, Holland, England and Western Germany and is registered under No. VFA019 with the Advisory Committee on Voluntary Foreign Aid of the Department of State.

The response of the medical profession to the Plan has been gratifying, but additional Foster Parents are required to alleviate at least the most heart-breaking cases of neglect and despair. The following physicians in this vicinity (who are Foster Parents) will gladly furnish additional information if desired:

Dr. Anne Benjamin
664 N. Michigan Ave.
Chicago, Ill.

Dr. Rudolph D'Elia
17084 Winchester Ave.
Hazel Crest, Ill.

Dr. Darwin Kohl
LaGrange, Ill.
(Temporary Address:
Dept. of Ophthalmology
V.A. Center
Wood, Wisconsin)

Dr. Max Samter
215 N. Elmwood Ave.
Oak Park, Ill.

Dr. Zelda Teplitz
612 N. Michigan Ave.
Chicago 11, Ill.

Dr. James H. Wallace
165 North Harvey Ave.
Oak Park, Ill.

COOK BOOK FOR LOW SODIUM DIET

A low sodium diet need not be a poor compromise with good eating. It is possible to conform to this dietary restriction without depraving gustation. Savory flavors of good meat and vegetables can be brought out with seasonings that are not harmful. Interesting, varied and nourishing menus can be prepared. The development of such menus requires time, experience and patience.

If you desire, you may take advantage of work already done in this regard, by using "THE COOK BOOK FOR LOW SODIUM DIET," which we have available for physicians to distribute to their patients. This booklet was prepared by the Massachusetts Heart Association and released for national distribution through the American Heart Association. It represents the thought and effort of outstanding nutritionists. It not only aids the person who has to cook for a patient on a sodium-restricted diet, but is also considerate of the needs of other members of the family who are not on such a diet. By its use, the day-to-day job of keeping the entire family well fed and happy is made easier.

You may obtain such booklets, without cost, by writing the Bureau of Heart Disease Control, Illinois Department of Health, Springfield, Illinois.

COURSE IN CEREBRAL PALSY

A special course in Cerebral Palsy, limited to physicians only, will be given at the Cook County Graduate School of Medicine, from June 15th through June 26th, 1953, under the direction of Dr. M. A. Perlstein, of Chicago.

Enrollment in the course is limited, and all applications should be sent directly to the Registrar of the Cook County Graduate School of Medicine.

ANNUAL CONVENTION OF THE INTERNATIONAL ACADEMY OF PROCTOLOGY

Prominent Chicago physicians will be well represented at the Fifth Annual Convention of the International Academy of Proctology at the Plaza Hotel, New York City, May 29, 30 and 31st, directly preceding the American Medical Association Meeting. Dr. Leo L. Hardt of the Cook County Postgraduate School of Medicine

will speak on the Diagnosis and Medical Management of Chronic Diarrheas. Dr. Edward J. Krol, President-elect of the International Academy of Proctology, will present a paper on Volvulus of the Sigmoid.

Dr. Max S. Sadove of the University of Illinois College of Medicine will discuss Ravocaine In Rectal Surgery. Dr. Norman I. Albert of the Herrin Hospital, Herrin, Ill., will discuss Techniques Suitable For The General Practitioner.

Dr. Manuel G. Spiesman, Associate Professor of Proctology, Chicago Medical School, will evaluate the Injection Treatment of Hemorrhoids. Dr. Caesar Portes, Associate in Proctology at Chicago Medical School, will discuss the Role of the Proctologist in Cancer Control.

The meeting at the Plaza Hotel will be preceded by demonstrations of surgical techniques and the presentation of scientific papers at the Jersey City Medical Center, under the direction of the Chief of Surgery, Dr. Earl J. Halligan, on May 28th.

The final day of the Convention will present a Motion Picture Seminar of Proctologic Surgery, including the latest developments in Ambulatory Office Techniques.

Because general practitioners, as well as gastroenterologists and proctologists, face proctologic problems in their daily practice, much of the program has been planned to answer their questions.

There is no fee for attendance at the Annual Convention of the International Academy of Proctology. These Conventions, as well as all other activities of the Academy, are directed toward the further development of proctology. All physicians interested in proctology are therefore invited and welcomed to the Annual Meeting.

The complete program will be available in the near future, upon request to the Executive Offices of the International Academy of Proctology, 43-55 Kissena Blvd., Flushing, New York.

Reasonably complete control of tuberculosis is attainable only where nutritional and other hygienic standards are high. C.-E. A. Winslow, The Cost of Sickness and the Price of Health, WHO Monograph Series, No. 7, 1951.

ANNUAL ASSEMBLY IN OTOLARYNGOLOGY

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology, divided into sections:

A. Basic Section, September 21 through 26, 1953, devoted to surgical anatomy and cadaver dissection of the head and neck, and histopathology of the ear, nose and throat, under the direction of Dr. M. F. Snitman.

B. Clinical Section, September 28 through October 3, 1953, consisting of lectures and panel discussions, with group participation of otolaryngological problems and current trends in medical and surgical management.

Registration will be limited. Application for attendance at one or both sections will be optional. For information write to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

NEW BIOANALYTIC CHEMISTRY JOURNAL

A pioneering journal in the science of bioanalytic chemistry is being launched by The John Crerar Library, Herman H. Henkle, Librarian, announced today.

The new quarterly, ABT, will serve a field that has grown tremendously in the last few years with rapid medical advances in disease detection through chemical analysis.

ABT, an abbreviated name for Abstracts of Bioanalytic Technology, is expected to find wide usage as a manual for hospitals, state and federal institutions and private laboratories conducting research on human ailments. The editor is H. E. McDaniels, Ph.D., who heads the Illinois Department of Public Health's bureau of laboratory evaluation.

Two especially timely articles covered in the first issue deal with grave problems of this atomic age: measuring human radioactivity and preventing radiation exposure.

ABT's abstracts will follow a cookbook formula, presenting step-by-step procedures for new or improved methods of chemical analysis. Each issue will contain approximately 50 abstracts. Material is being gleaned from 1,000 technical journals published in English, French,

German, Spanish, Japanese and other languages.

The quarterly is being prepared by the Crerar Library's Research Information Service for a new organization, the Council of American Bioanalysts. The group was formed by the Illinois and California associations of clinical laboratories, with plans for expanding into a national organization. Present membership numbers 140 laboratories. Council leaders serve as a technical advisory board for the new publication.

Particularly pertinent discussions in the first issue are those dealing with radioactivity. One abstract describes methods of preventing radiation exposure when working on specimens from patients who have been treated with radio isotopes. It also gives procedures to be followed in performing autopsies on radioactive corpses.

Another abstract recommends increased use of the scintillation counter in place of the well-publicized Geiger counter. The scintillation counter has been used extensively by the Atomic Energy Commission but its general application to the chemical laboratory has not been previously established. The article reports the scintillation counter to be more stable and efficient in measuring radioactivity of blood specimens, urine, plasma and other biological specimens.

Other currently topical abstracts report on improved laboratory techniques for: measuring a person's alcohol absorption, measuring fluorine content in drinking water (used to prevent tooth decay), detecting the size of viruses, measuring blood glucose (used in determining diabetes), testing for fungus infections on skin, hair and nails, and discovering liver diseases in infants. One abstract compares the accuracy of popular venereal disease tests.

The subscription rate for ABT is $5.00 a year from the Council of American Bioanalysts, 7 West Madison Street, Chicago 2, Illinois.

STATEMENT OF THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

The National Foundation for Infantile Paralysis makes the following statement upon the recommendation of its Advisory Committees on Research and Education:

"The Office of Defense Mobilization, a governmental agency, has been designated the allocating authority for the nation's entire supply of gamma globulin. Inasmuch as this blood fraction is effective in preventing measles, infectious hepatitis and poliomyelitis, and because this substance is in very limited supply, allocation of the nation's stockpile through a central agency was decided upon as the most effective way to prevent the greatest number of cases of these diseases.

"We have just learned that the Office of Defense Mobilization has announced its plan for allocating gamma globulin for use against poliomyelitis. The basis for the plan as announced was recommended by a special panel appointed by the National Research Council, a quasi-governmental agency.

"We note with some concern that in accordance with this plan, the greater part of the nation's stockpile of this scarce material may be used in a manner for which direct proof of efficacy is lacking. Reference is made here to the recommendation that gamma globulin be administered to household and other intimate contacts of patients suffering from poliomyelitis and, in certain circumstances, even to contacts of individuals suspected of having poliomyelitis.

"The field trials conducted during the summers of 1951 and 1952, with financial support of the National Foundation for Infantile Paralysis, demonstrated that gamma globulin, when administered during an epidemic of poliomyelitis to individuals in those age groups subject to greatest risk, provides some temporary protection against the paralytic form of this disease. Whether or not gamma globulin will be equally effective when used in some other manner is unknown. The field trials further provided suggestive evidence that those individuals who develop poliomyelitis following administration of gamma globulin develop a less severe form of the disease.

"While it is true that in a population group made up entirely of individuals who are contacts of persons with poliomyelitis, there develops subsequently an unusually large number of cases of this disease, it is also true that approximately 75 per cent of these 'secondary' cases occur within six days of the time the first case in the family has been diagnosed. Whether or not gamma globulin will prevent poliomyelitis when it is administered to contacts of diagnosed cases is unknown.

"We know that gamma globulin is not effective if administered to patients after signs of the disease are apparent. We also know that most, if not all, contacts of cases of poliomyelitis are already infected with the virus by the time the first case in the family has been diagnosed. In fact, there is good reason to believe that such individuals might have been infected for a period of several days. *IF* the blood fraction is to be administered to contacts of cases, the important and as yet unanswered question is 'Has the disease already advanced beyond the point where gamma globulin can prevent paralysis?' There is good reason to believe that there will be many contacts of cases of poliomyelitis who will become paralyzed even though they receive gamma globulin.

"The National Foundation's Advisory Committees on Research and Education have heretofore recommended and continue strongly to recommend that the major portion of the nation's stockpile of gamma globulin, available for use in poliomyelitis, be reserved for mass injections of children in the most severe polio epidemics of 1953. This recommendation is made because it is the only method so far proven to be effective against poliomyelitis. The Advisory Committees recommend further that the smaller portion of this scarce material be used in conjunction with contacts of diagnosed cases of poliomyelitis. It is hoped that, in connection with this latter use, adequate studies may be carried out so that we may learn whether or not gamma globulin employed in this manner can prevent paralytic poliomyelitis effectively."

The National Foundation stands ready to assist State Health Officers who may elect to employ community-wide injections of gamma globulin in an effort to halt an epidemic of poliomyelitis. It is prepared to provide specially trained personnel and such items of equipment as would not ordinarily be available in many communities.

CHICAGO DERMATOLOGICAL SOCIETY ELECTS NEW OFFICERS

At the annual meeting of the Chicago Dermatological Society held January 21, 1953, the following officers were elected:

President: Samuel J. Zakon, M.D.

Vice-President: William K. Ford, M.D., Rockford, Ill.

Secretary-Treasurer: Irene Neuhauser, M.D.

COMPLIMENTARY BREAKFAST FOR WOMEN PHYSICIANS

The annual complimentary breakfast to all women doctors as guests of the Illinois State Medical Society during the annual convention will be held May 20th — at 8:00 a.m. in Room 114, the Gold Room of the Sherman Hotel. Tickets may be obtained at the registration desk. Speaker at the breakfast will be Norma Lee Browning, feature reporter of the Chicago Tribune. A hospitality room will be be available during the convention. The room number will be posted at the registration desk.

CAUTION

No antibiotic aerosol should ever be used unless there is reasonable evidence of purulent infection of bacterial origin being present. To do so in allergic individuals without considering or anticipating possible serious undesirable side reactions is extremely hazardous. To expect a good clinical response where there is no clear indication for the use of a specific aerosol is faulty judgment, and any failure should not be used as evidence against a valid technic.—*Paul F. Jaquet, M.D. Inhalational Therapy. Med. Ann. District of Columbia, Sept.* 1952.

ORIGINAL ARTICLES



The Surgical Treatment of Duodenal Ulcer

Karl A. Meyer, M.D., and I. F. Stein, Jr., M.D., Ph.D.
Chicago

Most clinicians agree that strict medical management is the best treatment for uncomplicated duodenal ulcer. Sharp controversy exists, however, concerning the best surgical procedure for the complicated duodenal ulcer. Gastrojejunostomy alone is seldom advocated today, due to an unfavorably high incidence of postoperative gastrojejunal ulceration. Gastric resection has become the procedure of choice due to improved clinical results. There remains, however, a relatively small group of patients who have unpleasant symptoms or recurrent peptic ulceration following gastric resection. The question arises as to whether vagotomy and gastrojejunostomy will produce as good or better results than gastric resection with a lower mortality.

Evaluation of a surgical procedure for peptic ulcer depends upon two factors; first the physiologic basis for the operation and second the clinical results.

The physiologic basis for gastrojejunostomy is indeed meager. The performance of a simple gastrojejunostomy does little to alter gastric function. The secretory capacity of the stomach is unchanged and the regurgitant neutralization is probably a negligible factor in ulcer healing. Healing of a duodenal ulcer takes place after gastrojejunostomy owing to the diversion of a portion of the gastric contents away from the ulcer-bearing area in the duodenum, and directly into the jejunum. This, however, also accounts for the appearance of a jejunal ulcer. Thus simple gastrojejunostomy is followed by an unfavorably high incidence of anastomotic ulceration, and its use in recent years has been suggested only for the aged patient with a high degree of pyloric obstruction and a low level of acidity. In such a patient there is no assurance that hyperacidity will not return after the obstruction has been relieved; therefore it is preferable to perform both a gastrojejunostomy and a vagotomy.

Adequate gastric resection is followed by a low rate of recurrent peptic ulceration. This is achieved by adherence to the three basic principles. First, a sufficiently large amount of gastric fundus must be removed. This means

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that minimum of two-thirds and preferably three-fourths of the stomach must be resected. If only 50 percent is removed, the remaining gastric pouch will often possess a large secretory capacity; thus, anastomotic ulcer is likely to occur. Second, the entire antrum must be removed. Although the antrum forms no free acid, it secretes gastrin, the gastric hormone which stimulates the acid-secreting cell in the fundus. If the entire antrum is not resected the remaining gastrin mechanism may produce increased acid response even in a case of adequately high resection. Third, the length of the jejunal loop leading to the anastomosis should be as short as possible without causing any mechanical disturbance. It has been shown experimentally that the resistance of intestinal mucosa to acid-pepsin decreases progressively as the distance from the stomach increases[1]. Thus, in general, the greater the length of the proximal loop, the greater the possibility of a recurrent ulcer. This raises the question whether a "no loop" posterior anastomosis is preferable to a short loop anterior anastomosis. Actually we have not seen a greater number of recurrent ulcers following anterior gastrojejunostomy when the loop is constructed just long enough to extend over the colon without tension. Enteroanastomosis diverts the alkaline duodenal contents away from the gastrojejunostomy and should not be employed.

Ample exposure is a necessity for the performance of an adequate gastric resection. A long, high right rectus or paramedian incision affords sufficient exposure for mobilization of the duodenal stump and in a thin patient also allows one to perform a high gastrectomy. Because this incision does not offer ample exposure in the heavy-set, squat or obese patient, Dr. Peter A. Rosi has recently suggested that for such patients a bilateral subcostal incision should be used. We have employed this incision in selected cases for the past three years and find that it offers excellent exposure both for duodenal closure and for the accomplishment of a high gastric resection.

Great care must be taken in the performance of a vagotomy to assure that as many vagus fibers as possible are transected. There are usually two main vagus trunks at the level of the diaphragm, whether the approach is from above or from below. However, we have seen histologic proof of eight nerve branches at this level. Even when great care is taken to sever all vagus fibers, there will be an incomplete vagotomy in at least 10 to 20 percent of cases. Clinical evidence concerning the necessity of complete vagotomy is as yet inconclusive. Although the majority of recurrent peptic ulcers following vagotomy have occurred after incomplete vagus section, there are many patients who have had a good result for three or four years after incomplete vagotomy. Physiologically there is a possible explanation for this apparent inconsistency. We have retested 25 of our vagotomy patients three to four years after operation and find that they may be divided into three functional groups, as follows[2]: 1. No vagus function (complete vagotomy); 2. Partial vagus function; 3. Normal vagus function.

The best indication of vagus function, of course, is the insulin test, since an acid or motor response of the stomach to insulin hypoglycemia is positive evidence of incomplete vagotomy. In addition, any other evidence of unchanged secretory capacity is suggestive of incomplete vagotomy. Thus, if the spontaneous secretion of the stomach, i.e., the night secretion or basal secretion remains elevated, or if the postoperative response to histamine or caffeine is unchanged, we immediately suspect that functional vagus fibers are intact.

Patients with no vagus function consistently have no free acid response to insulin hypoglycemia and no free acid during periods of spontaneous secretion. In each case there is a reduced secretory capacity in response to all stimuli, including histamine. In some instances there is absolute achlorhydria. There is also absence of the vagal type of motility. There is no evidence of any return of vagus function in this group and these findings are persistent up to four years after vagotomy. The patients in this group, in general, have shown excellent clinical results.

Evidence of partial vagus function is provided by a slight acid or motor response to insulin hypoglycemia and often by free acid secretion of the unstimulated stomach. The results of the original postoperative insulin test in some of these cases were considered equivocal, whereas repeated tests over a period of years have of-

fered definite proof of incomplete vagotomy. There is a slight return of gastric function in this group of patients three to four years after vagotomy, as has been shown by basal secretion studies. It should be emphasized, however, that in spite of this small increase over the early postoperative result, there is still a 66.2 percent decrease as compared to the preoperative secretory rate, and there remains a 70 to 80 percent decrease in response to histamine and caffeine in the late period as compared to the preoperative response[2]. Patients in this group have a so-called "incomplete vagotomy"; however, only partial vagus function is present with the marked persistent decrease in secretory capacity. Clinical results in this group have been generally good, but the period of follow-up is as yet insufficient to assure that this is permanent.

There is no indication of a change in gastric function or of any decrease in the secretory capacity of the stomach in patients with normal vagus function. Recurrent peptic ulcer has been common in this group.

Thus there is little, if any, physiologic basis for the use of gastrojejunostomy in the treatment of duodenal ulcer. A properly performed gastric resection on the other hand results in a permanent and marked decrease in gastric secretory capacity of the stomach. Vagotomy will result in a similar permanent and marked decrease in gastric secretory capacity only in those cases in which all, or nearly all, of the vagus fibers are transected.

A clinical study of vagotomy and gastric resection is being conducted by the American Gastroenterological Association. The most recent report by Dr. Sara Jordan[3] includes data on 1300 duodenal ulcers treated by vagotomy with an average follow-up of two and one-half to three years; and 1036 subtotal gastrectomies for duodenal ulcer with a slightly longer follow-up. Although it is still too early to make a final decision it appears that subtotal gastric resection has produced better results in the control of ulcer disease than gastrojejunostomy plus vagotomy. On the other hand, the surgical mortality following vagotomy is lower than that following subtotal gastric resection.

In view of the previous discussion, what surgical procedure at present is recommended for the complicated duodenal ulcer? In general we consider gastric resection to be the operation of choice. There are, however, certain indications for the use of vagotomy. The most definite indication is in the treatment of a gastrojejunal ulcer occurring after a high subtotal gastrectomy. In such cases re-resection may be a difficult and hazardous procedure. In addition there are several relative indications which are influenced by the severity of the pathology and the general condition of the patient. The relative indications are: 1. The acutely inflamed edematous duodenal ulcer; 2. The anastomotic ulcer occurring after simple gastrojejunostomy; and 3. The anastomotic ulcer occurring after an inadequate gastrectomy. In general gastric resection is preferred; however, when severe inflammatory reaction is present or in the poor risk patient, vagotomy may be indicated.

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DISCUSSION

Dr. J. C. Rogers (Urbana): Would you care to enumerate your occasions for vagotomy, the cases in which you would favor that. I know you use it from time to time. Could you simplify?

Dr. Karl A. Meyer: The patients on whom I do vagotomy are individuals of a younger age group. In other words, we see families of duodenal ulcer, two or three individuals in the family having their ulcer symptoms, 20, 21, 22 years of age. In instances like that, I prefer to do a gastro-enterostomy and vagotomy, in preference to a resection. In the older age group, we prefer to do a gastric resection.

Surgical Management of Colon Emergencies

Kent W. Barber, M.D.
Quincy

Spontaneous perforation of the large bowel, in the absence of malignant degeneration, may occur in chronic ulcerative colitis, diverticulosis with diverticulitis, severe gastroenteritis, nonspecific granuloma of the colon, simple ulcers of the type described by Wilkey, tuberculous enterocolitis, and in a normal segment of bowel with a distal obstruction. This discussion is limited to perforation in chronic ulcerative colitis and in diverticulitis.

Perforation from chronic ulcerative colitis remains a serious complication. Fortunately, it is not as frequent as the other complications of the disease — namely, polyp formation, strictures, massive hemorrhage, and malignant degeneration.

In a series of 2,000 patients with chronic ulcerative colitis reported by Bargen at the Mayo Clinic between 1918 and 1938, there were 87 patients with perforation (4 per cent). About one in 10 of this group had multiple perforations and approximately half (48) subsequently progressed to fistula formation. Of the total group, 107 (5 per cent) developed neoplastic lesions. Approximately 10 per cent of this series of 2,000 patients with chronic ulcerative colitis developed serious complications demanding surgical care.

There is considerable diversity in the area, extent, and variation of the disease. Some patients go along fairly well for 12 to 15 years with advanced ulcerative colitis, encountering the characteristic remissions and exacerbations; others may die with multiple perforations within 10 days of its onset. Between 65 and 90 per cent of all chronic ulcerative colitis cases can be handled indefinitely by careful medical management. But surgery is indicated:

When the application of carefully considered measures fail to control the problem.

In perforation of the colon with its complications of abscess and fistula.

With stricture formation.

In severe bleeding.

If there is danger of malignant changes in a colon with long standing diseases and polypoid changes.

Thorlaksen and Patterson[2] suggested recently that we must aim not at early operation but at operation earlier than was done in the past on properly selected patients—surgery which is done before the patient develops perforation or carcinoma. Several groups have reported a mortality of 0 to 2 per cent in elective ileostomy, depending on the stage.

The operative mortality from simple ileostomy 10 or 15 years ago was about 20 per cent in most clinics. Internists and patients alike rightfully avoided such a high operative risk with a final result of an excoriated, painful, self-digested abdominal wall. Consequently surgery was delayed until the patient was in such a serious state from advanced toxic changes of the disease that an almost prohibitive surgical mortality resulted. Lahey reports three understandable suicides among their first 145 ileostomies because of the suffering from skin digestion and the exclusion of these patients from acceptable lives because of the depression brought about by an ileostomy that could not be well controlled.

Recent gratifying surgical refinements in the making of an ileostomy and in its subsequent management by the use of adherent bags after operation and the feasibility of later removing a badly infected colon and rectum have changed completely our former concepts of ileostomy with colestomy. Following the suggestions of Crile, the patient who has had the opportunity of trying out the adherent plates of the Rutsen type bag to his skin in several different locations prior to final operation, is bothered much less with it than is the patient who has not had this opportunity. A stoma placed too close to the umbilicus, the anterior-superior spine, or the groin will not be watertight and will cause considerable discomfort in various bodily positions. Another source of great discomfort to the patient may be

The Quincy Clinic.

avoided by preventing fistulous formations about the ileostomy where the ileum has been sutured to the abdominal wall.

Cattell, of the Lahey clinic, has suggested that only the mesentery be sutured to the parietal peritoneum. If this is done, there is no danger of either the ileum slipping back within the abdomen or of small stitch abscesses with subsequent fistulae formation about the ileostomy. In the acute phases of the disease, Lahey does the simplest type of loop ileostomy, avoiding exposure of the peritoneal cavity and handling of the bowel. He feels that an attempt to do a divided ileostomy, implanting the distal end elsewhere in the abdomen at the first stage, will result in an avoidably high fatality rate. The use of split skin graft about the ileostomy is certainly a moot question at present. While the plan was favorably received a few years ago, many surgeons have experienced difficulty in getting the graft to heal completely and not subsequently break down at the angles. There also seems to be a tendency for skin grafted ileostomies to tighten down and they require dilatation more often than those without graft.

Perforation in ulcerative colitis must be handled the same way as any other perforation. In acute perforation of a bowel that has not been diseased too long, it may be possible to close the perforation with stitches or an omental plug. The bowel wall in longstanding ulcerative colitis is extremely friable and cicatrized, holds stitches poorly, and will not invert. In any event, all closures must be combined with ileostomy. If the perforation cannot be closed, it must be drained temporarily at the time of the ileostomy, followed later by resection of the colon.

I would like to present two patients with chronic ulcerative colitis, both of whom could have profited by earlier surgery.

A 46-year old paint salesman had weighed over 200 pounds prior to his illness. When first seen, he gave a three-year history of 8 to 15 watery, bloody stools per day accompanied by marked weight loss. A positive diagnosis of ulcerative colitis had been made three years previously and, in the interim, the man had visited several well-known institutions. Treatment consisted of various trials of all the antibiotics as well as dietary and psychosomatic measures, the last of which included sending him home to his farm. But weight loss continued until, on admission, he weighed 87 pounds; he was anemic, cachetic, and extremely ill. His white blood count was elevated and his serum protein reduced.

A barium enema x-ray study of the colon showed an advanced ulcerative colitis pattern in the entire colon with shortening and narrowing of the lumen. The entire mucosal pattern throughout was shaggy and ragged. In the midportion of the descending colon there was an irregular, ragged narrowing with escape of the barium out of the lumen at the side of perforation, with large, polypoid filling defects in cecum and descending colon. The radiologist was unable to determine whether these lesions were neoplastic degenerations or pseudopolyps.

After one week's preparation, an exploration was done. The terminal 14 inches of the ileum were found to be hard, ropey, and grossly inflamed. The cecum and first portion of the ascending colon were bound down by dense, old adhesions. No further exploration was done. The ileum was divided about four inches proximal to the segment involved in the ileitis. This loop was brought out through a separate stab wound in the right lower quadrant. The proximal loop was freed of its mesentery, sutured to the peritoneum at the mesentery, and a tube dermatome skin graft applied about the ileum. A total colectomy was done subsequently and no malignant degeneration was found. The patient made an uneventful recovery and has regained the 113 lost pounds. He now weighs 200 pounds and is actively engaged in farming.

The second patient, a 32-year old housewife, was admitted to the hospital on July 5, 1951 with a history of one week of bloody diarrhea. For about eight months prior to that time she had suffered from increasing constipation which necessitated a daily enema. A barium enema x-ray study showed complete loss of haustrations throughout the transverse, descending and sigmoid colon with a fine, shaggy, saw-toothed pattern to the mucosa of the sigmoid and rectal ampulla. The remainder of the bowel was normal. Proctoscopic examination was typical for idiopathic colitis with an easily bleeding, ulcerated mucosa, smears of which showed no ameba.

During the next three weeks in the hospital

she was given intensive medical treatment including antibotics, absorbable and non-absorbable sulfa products by mouth, and multiple transfusions. Profuse intestinal hemorrhages continued, however, which were increased when cortisone and ACTH were tried. Abdominal distension and signs of peritonitis developed and before ileostomy was consented to, the patient died —four weeks after the onset of the acute phase. Post mortem revealed a dilated, soft, fragile colon with multiple perforations. There was extensive ulceration of the mucosa; only a small portion remained intact. The wall of the bowel had not become thickened or cicatrized and would have lent itself well to temporary suture.

Diverticulitis is another disease in which the modern surgical approach has changed our previous convictions. Too much unfounded fear of surgical relief of this disease and its complications still exists. About 5 to 10 per cent of all adults have diverticulosis and about 10 to 20 per cent of this group suffer eventually from diverticulitis. The exact incidence of perforation in diverticulitis with peritonitis or local abscess formation is difficult to evaluate. Smithwick suspects that one in 2,000 people over 40 years old comes to operation because of complications of diverticulitis. In 202 cases of complications of diverticulitis necessitating resection, reported by Mayo in 1950, obstruction was the initial complaint in 83. The next most common complication was abscess, which occurred in 57 of whom 16 developed obstruction eventually.

Approximately 85 per cent of all diverticula occur in the descending and left colon, with the remaining 15 per cent in the right colon. Because of the nature of the fecal stream, perforation in the left colon is more likely to be accompanied by local abscess formation than when the perforation occurs in the right colon with a more fluid fecal stream. Because of the lower incidence of diverticula and diverticulitis in the right colon, the literature is sparse in reports of such cases. Henry reports three cases, in all of which he was able to excise the diverticula with the associated inflammatory mass and close the defect in the thecal wall with reinforced suture. Guy and Werelius report a similar case with acute perforation of diverticulitis in the right colon.

Acute perforation of diverticulitis in the right colon generally presents an acute abdominal emergency that ordinarily is mistaken for appendicitis or perforated peptic ulcer with leakage down the gutter to the right lower quadrant. Many of these patients have been handled successfully with simple closure of the perforation, the defect being reinforced with fat. This usually is possible unless the perforation is so large, or the associated inflammatory response so extensive, that resection of the involvled segment of bowel is indicated either because of the extent of the disease or the impossibility of determining the presence or absence of malignant degeneration.

In perforation of the left colon, the heavier fecal stream usually does not produce as much gross peritoneal irritation. Localized abscess is more likely. Consequently, preoperative preparation and more thorough diagnostic measures frequently are utilized and unless the perforation and subsequent abscess formation have caused obstruction, hasty surgery is unnecessary.

In the surgical approach to this problem, if simple drainage of the abscess is all that can be done, a persistent fistula will develop in practically 100 per cent of the cases. Pemberton and Black have emphasized the fact that there is always a possibility of recurrence of diverticulitis when the involved bowel segment is not removed. In general, because of the danger of subsequent obstruction and/or recurrence of diverticulitis with further perforation, the surgical method of choice is removal of the involved segment.

Four surgical approaches are available: 1. Simple drainage; 2. Primary resection with anastimosis. 3. Mikulicz's extraperitoneal type of resection. 4. Three stage procedure involving a preliminary diversional colostomy followed by primary resection and closure of the colostomy.

Simple drainage is used only in the critically ill patient who cannot tolerate the additional hazard of a simple proximal colostomy. If the patient survives, a fecal fistula will have developed, necessitating future surgery. Primary resection with end to end anastomosis rarely can be carried out, being reserved for a small group of elective cases when the disease is in a quiescent stage and adequate preparation is possible. Resection must be wide because anastimosis of any diseased bowel wall will be followed by fistulous

formation. The Mikulicz extraperitoneal type of obstructive resection can be done occasionally in suitably located lesions. If there is difficulty in mobilizing the lesion without entering too many planes of tissue infection, this method must be abandoned in favor of simple diversional colostomy and drainage of the abscess formation about the diverticulitis. The colostomy should be in the transverse colon as sigmoid colostomy will seriously impair future resection. The last method of managing this type of perforation is best and most frequently used. An attempt may be made to close the perforation with omentum or epiploic appendages, the involved region is drained, and the fecal stream is diverted by means of a transverse colostomy. This method puts the involved bowel at rest, allows adequate drainage, and produces optimal conditions for healing. Furthermore, the diseased section of the bowel can be prepared for resection at a later date.

Two cases of diverticulitis with perforation illustrate fairly typically the problems encountered:

A 35-year old man came in with a typical history of acute appendicitis of six hours' duration. At operation, the peritoneum was found to contain thin, purulent fluid. The appendix was normal but there was a large, hard mass at the tip of the cecum which felt almost malignant. On dissection this mass proved to be fat and scar tissue over acute diverticulitis which was leaking. We were able to excise the area and close the cecal wall defect with interrupted sutures. A postoperative x-ray film showed all the diverticula located in the right colon.

The second patient suffered from a sigmoidovesicle fistula which was known to have been present for at least 10 years. The man had encountered characteristic symptoms of recurring bouts of diverticulitis during all this time. It was interesting to note from the x-rays that although the opaque fluid which was passed into the bladder went readily into the sigmoid, when the barium was passed into the sigmoid, it did not enter the bladder. No great amount of pressure was put on this fluid but the reverse valve action is what kept this patient from having too severe kidney damage despite the presence of a sigmoidovesicle fistula for many years. From the radiologist's standpoint, this lesion was typical of carcinoma and, at operation, the resected specimen would have been difficult to tell from malignancy by palpation alone. The walls about the fistula measured from 1½ to 2 cm. in thickness with a hard, cicatricial mass. An unfounded fear, based on earlier statements, kept this man a semi-invalid for over 10 years.

The literature cites an ever increasing number of victims of acute diverticulitis with perforation or obstruction who have been relieved of symptoms by resection of the involved segment of bowel and diverticula. No doubt many persons are forced to live with the complications of diverticulitis, on an inadequate diet, with varying degrees of morbidity. In the future, such cases should and will be relieved of this disability surgically. In chronic ulcerative colitis, we would re-emphasize the suggestions of Thorlaksen and Patterson that we strive for earlier surgery with patients who eventually are bound to seek surgical relief for ulcerative colitis which is refractive to medical treatment or undergo one of the serious complications of the disease.

For references, consult the author 1416 Maine St., Quincy, Illinois.

The Diagnosis and Treatment of Allergic Rhinitis

Walter E. Owen, M.D.
Peoria

In the practice of otolaryngology today it becomes increasingly evident that allergy plays a major role in chronic nasal and sinal disease. In the past many failures in both medical and surgical treatment can be attributed to either a lack of or an inadequate knowledge of allergy as the basic or complicating factor.

It is not the purpose or scope of this paper to enter into a discussion of the basic fundamentals of physiology and immunology which are the present day explanation of the allergic reaction. There are many questions yet unanswered, experimental investigators are working diligently on these problems with encouraging results. We do know that the allergen or antigenic substances to which the body becomes exposed and absorbs in varying concentrations coming in contact with the sensitizing substance or reagin of the blood stream is the probable explanation of the sensitized cell or complex cellular structure.

The role played by histamine in the allergic reaction has been the object of study by Code[1], Roth and Horton[2], Katz and Cohen[3], Dragstedt[4], and innumerable other investigators. Its presence in tissues has been definitely established and the accumulated evidence points to the fact that histamine is released by the sensitized cell upon contact with additional antigen and that the amount of histamine released is in relation to the degree of the reaction.

The three major efforts noted on the histamine release are:

1. Increase in the secretion by the mucous glands.
2. Contraction of smooth muscles.
3. Dilation and increased permability of the capillaries.

The presence of histamine in the allergic reaction is the rationale which has brought about the development of various antihistaminic drugs for the control of hay fever and other allergic manifestations.

Throughout the years as the specialty of Otolaryngology has developed, masterful contributions have been made to our knowledge of the anatomy of the head and neck. There is little to be added to that knowledge. Surgical procedures have been developed and perfected to such a point that they are well standardized within certain variable limits. In more recent years attention has been focused on a greater understanding of the physiology, pathology and immunology of nasal and sinus disease.

Allergy of the nose and para-nasal sinuses is a problem which confronts every Otolaryngologist in his daily practice. Vasomotor rhinitis, catarrhal rhinitis and hyperesthetic rhinitis are terms which many use interchangeably. Dr. French K. Hansel[5], of St. Louis, an Otolaryngologist, became dissatisfied with the results using the accepted methods of treatment in these conditions. He was one of the first to call our attention to the underlying allergic factor in them. He was also one of the first to use allergic methods of therapy in these cases and he noted great improvement in his therapeutic results. In his monograph, "Allergy of the Nose and Paranasal Sinuses", Hansel has correlated the fundamentals of nasal physiology, immunology and the clinical manifestations of nasal allergic disease.

The chronic non-surgical conditions occurring in Rhinology can be classified as follows:

1. Infection
2. Infection and Allergy
3. Allergy.

Acute and chronic sinusitis of the infectious type are common clinical entities. We are all familiar with the onset, clinical course, gross and microscopic pathology and diagnosis. The treatment of these conditions varies in the hands of the individual, operative procedures are well

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standardized. It is quite common for these diseases to be limited to a single sinus or to one side of the nose, while the other sinuses or the opposite side of the nose are free from involvement.

Chronic sinusitis complicated by allergy presents additional factors of pathology and problems of diagnosis. There is an edema which involves the nasal mucous membrane as well as that of the suppurating sinus and other sinuses, the opposite side of the nose is nearly always involved. There is an abundance of mucous secretion as well as the purulent secretion. Often there is the typical pale, glistening, boggy membrane. There is blockage due to the edema present which causes a stasis in the involved sinus making a cure by local methods very difficult and often impossible. Following radical surgical procedures the underlying allergic factor will frequently cause a return of the sinus infection. The nasal secretion when examined microscopically will be found to contain an eosinophilia as well as a neutrophilia. Nasal polyposis is quite common. The pathologic picture may be one of mild allergy and severe infectior or vice versa.

In typical allergic rhinitis the mucous membrane is pale, watery, boggy and has a glistening appearance and there is an abundant mucous or watery secretion. One or both sides of the nose may be completely blocked by swollen turbinates. Post-nasal drainage is usually present as whitish mucoid bands on the posterior pharyngeal wall or as a mass of glistening mucous in the nasopharynx, which can often be seen moving downward. Eosinophiles are abundant in the nasal and in the post-nasal secretion.

Neutrophiles are present but not as common as eosinophiles. Polyps are very common, often causing obstruction to one or both sides of the nose. If of long standing, they may be seen without the aid of a speculum.

In atypical or mild allergy the mucous membrane will often appear about normal or slightly reddened. Instead of the watery secretion there may be only mucus or even mucus bands across the air passage between the turbinates and the septum. There is nearly always a certain degree of post-nasal discharge, the character of which has been previously described. Eosinophilia of the nasal secretion is present. In this type polyposis is the exception rather than the rule.

Allergic rhinitis is caused primarily by inhalants such as pollens, various types of dust, animal eminations, atmospheric or air-borne molds and cosmetics. There are secondary factors, such as foods, drugs and non-organic ingestants.

Pollen allergy is synonymous with hay fever; it falls into three seasons which are concurrent with the pollination of the trees, the grasses and the weeds. Tree pollination in Central Illinois begins early in March and continues to the last of April. Symptoms during this season are usually not severe. Grass pollens begin during the latter part of May and continue until July. Weed pollens begin in early August and continue until late September. Ragweed pollen, the greatest offender of all, because of its great abundance and marked toxicity usually starts between August 10th and 15th, reaches its height about Labor Day and continues on until the last week in September. Those patients who suffer until frost, are in addition, mold sensitive or have developed some secondary sensitivity during the season.

Perennial allergic rhinitis is seen in varying degrees of severity. The symptoms are no worse during seasonal hay fever unless it is complicated by pollen sensitivity. House dust or occupational dust, animal danders, cosmetics and foods are the usual excitant antigens in this group.

A detailed history regarding the onset of the present symptoms is important from a diagnostic standpoint. It often gives a definite lead as to the excitant factors. In children, nasal symptoms are often noticed following the onset of food allergies or skin manifestations. A very common assertion of the parents is that a child has had a continuous cold since onset of some infectious disease. Often an acute infectious rhinitis may merge into a chronic allergic rhinitis.

Symptoms may follow a visit to the country, at which time the child has come into contact with new-mown hay or freshly harvested grain, in which instance, grass or mold or both may have started the attack.

Home environment is an important factor. There are many allergens in the house dust, too numerable to mention, many are unknown frac-

tions, some or any of which may be responsible for the reaction.

Sudden thermal changes which produce physical allergies may initiate symptoms. Seasonal variations corresponding to pollination, change in cosmetics, drugs or other unusual contacts, change in residence or occupation, house cleaning, bedding, pillows, mattresses, and contact with dogs, cats and horses must all be considered.

It must be determined if the symptoms are of long or short duration, if the patient has had nasal treatments over long periods of time and the extent of nose and throat surgery. It is not unusual for a patient to state that he has had several surgical procedures in the nose.

Symptoms vary with the individual and with the causitive agent. Severe typical allergy is associated with sneezing paroxysms, marked nasal blockage, profuse mucoid or watery discharge. Posterior drainage and paroxysms of cough are common. Asthmatic symptoms are present in a relatively large percentage of severe cases.

In atypical cases the symptoms are usually milder, the only complaints may be nasal stuffiness, inability to blow the nose, post-nasal drainage and chronic cough; a cold that has persisted for several weeks or months.

Cytologic examination of the secretion is one of the most dependable diagnostic procedures. In pure allergy the cellular constituents are mainly eosinophiles with occasional neutrophiles, epithelial and round cells. In mixed allergy and chronic infection, neutrophiles and eosinophiles are both present. The eosinophiles are frequently found in clusters or groups, whereas, the neutrophiles are more evenly distributed throughout the field. In acute infection superimposed on allergy the neutrophiles may be so marked that they entirely overshadow the eosinophiles and until the acute phase subsides the eosinophiles do not reenter the secretion. In mild cases repeated examinations may be necessary to establish the presence of eosinophiles. One negative examination does not rule out the possibility of allergy.

X-ray findings of the sinuses in allergic disease are variable. They may show simple edema, chronic thickening of the membrane or even polypoid changes of marked degree. The x-ray may show normal sinuses shortly prior to an acute allergic reaction and after the reaction has developed a marked oedema may result. Recurrent attacks of acute oedema often result in a chronic thickening of the membrane. When the x-ray findings are correlated with the clinical findings, the history, and cytologic study, a more accurate diagnosis can be made. If on x-ray examination one finds a rather uniform density throughout the sinuses, it is highly suggestive of allergy rather than a chronic sinusitis.

Usually when a diagnosis of allergy is suspected in a patient with chronic nasal symptoms, it becomes necessary, because of the lack of facilities, to have an allergist in consultation for the completion of the diagnosis. The patient's problem however, still is one which pertains to Rhinology and it remains for the rhinologist, because of his specialized training and understanding of the nose, to continue in the care of the patient. In such patients, both phases of treatment must proceed hand in hand.

It is not necessary for the rhinologist to become an allergist in order to make an accurate diagnosis in 90% of his allergic patients, even though it is felt by some, every rhinologist should be his own allergist. The only necessary equipment which he needs is a set of pollen extracts common to his locality. The other common inhalants including house dust and a few of the most common foods of the daily diet together with a bottle of stain for the preparation of the nasal smear for cytologic examination.

There are two methods of skin testing in common use — the scratch test and the intracutaneous test. The scratch test should be used when concentrated extracts are used. There are many people who are mildly sensitive that will show no reaction by this test. The intra-cutaneous method is much more sensitive and should be used with dilute solutions and then only if the scratch test fails. Pollen extracts should be used in scratch testing, the other inhalants, house dust and foods should be used intradermally. It is for the occasional case that special testing and occupational dusts are necessary to complete the skin testing part of the diagnosis.

Skin testing is quite reliable when testing with pollen extracts. In these cases positive reactions and a positive clinical history give a dependable guide to the causative factor. Testing with food extracts is only 50% reliable at

best. Many patients will show a large number of positives to foods with which they never come in contact or there may be too many positive reactions to give a definite diagnosis.

In either method of testing, it must be remembered that a dermagraphic skin will give many false positive reactions — in these only a relative reading can be made.

The treatment of pollen allergy or seasonal hay-fever must be associated with a knowledge of the pollens which are present in the locality and the daily atmospherie pollen counts as recommended by Wodehouse[6]. The treatment may be perennial, preseasonal or co-seasonal. The preseasonal and co-seasonal method is as satisfactory as the perennial with less trouble and expense to the patient. However, many prefer the perennial method of treatment.

The use of the high dilution, small dosage method recommended by Hansel[7], is used. .02 c.c. of the following dilutions: 1-10,000,000, 1-1,000,000 and 1-100,000 are first tried as a guide to treatment. If a wheal of 10-15 mm. is noted with any one of these, then no further dilution need be tried and treatment is started with .10 c.c. of the next higher dilution. By using this method there is little or no danger of exacerbation of symptoms or constitutional reaction. The dosage is increased by .05 cc. at 5 to 7 day intervals and continued throughout the pollenating season, which in some cases may include all three seasons, until satisfactory dosage has been obtained.

In the treatment of all allergic disorders the ideal situation is to avoid or eliminate all the offending factors. This however, is often impractical or even impossible. This proves to be the case in inhalant allergy caused by house dust. Best results have been obtained by the use of a composite house dust extract given in small optimum dosage rather than in increasing concentrations or large top dosage.

Experience has shown that small doses of a dilution of 1-100,000,000 in the severe cases is satisfactory, while in those that are not severe dilutions of 1-10,000,000 give better results. In some of the atypieal cases with very mild symptoms the dosage may be as strong as 1-1,000,000. The dosage should be increased .05 cc at 5-7 day intervals until symptoms are under control and once a satisfactory dosage has been obtained it should remain there. The interval should then be lengthened from 7 to 10 days with a gradual increase in the time interval. Many patients do well on an interval of six weeks or longer once they are regulated.

When there is an exacerbation of symptoms, the dosage should be reduced by .10 cc. and if symptoms do not improve the next higher dilution should be used. In certain instances it is necessary to manipulate the dosage to arrive at the optimum dose. It is well to assume that if the symptoms are no better on increasing dosage, the extract is too strong. The optimum dosage in the same individual may vary at different times, and hence require further manipulation.

On cases of dust allergy there is frequently an associated mold allergy. Alternaria is the most common offender. It has been found that on the addition 10% mill dust as prepared by Wittich, which includes all the molds, rusts and smuts, that there has been improvement in the results obtained on mold sensitive patients.

In the management of food allergies, the clinieal history and skin tests give valuable clues. However, if results are not satisfactory by the elimination of such substanees, elimination diets as outlined by Vaughn[8], Rowe[9], Hansel[5] and Rinkle[10], may be necessary. The injection of food extracts has never proved satisfactory, although at the present time valuable work is being done along these lines which may result in better hyposensitization with extracts.

Nasal polyps have been the subjeet of much controversy for a number of years by many of the foremost authorities in otolaryngology. Various classifications, most of them on a pathologic basis, have been used. Among the early observers the classifications were mainly on the basis of infection, or hyperplasia. Until more recent years no consideration was given to the allergic origin of polyps. At the present time there are two schools of thought on this subjeet. One believes that infection is the primary factor and the other believes that allergy is primary and that infection is a secondary faetor. There is much evidence in the literature to support both views; however, there is increasing evidence that allergy plays the major role in the development of polyps.

It is not far amiss to state that nearly every

otolaryngologist has had the experience of having performed an ethmoidectomy with the removal of large masses of polypoid tissue and was satisfied with his operation upon its completion only to find that within a few weeks there was a recurrence of some of the polypoid tissue. It is not uncommon for a new patient to come into the office with a nose full of polyps, a history of having had them removed on several previous occasions, and on inspection to find the typical picture of an allergic nose with large oedematous polyps present. Such experiences as these indicate that the causative factor has not been adequately determined, nor is the treatment satisfactory. Because, in this group of patients, many will give a definite allergic history and present allergic symptoms, they should have a complete and thorough allergic study including the necessary laboratory work, cytologic determination of the nasal secretion, x-rays of the sinuses and skin tests prior to further anticipated surgery. If surgery is performed, microscopic examination of all tissue removed should be made. Allergic therapy should then be instituted in the followup treatment.

In a series of 77 cases of nasal polyps, 14 or 18.3% failed to return for further diagnosis or treatment and must be excluded from comparative figures. In the remaining 63 cases, 9 or 14.3%, no proof of an existing allergy could be substantiated. In 13, or 30.6%, the polyps were small, Grades I and II. There was a fair breathing space, no gross evidence of infection and a positive nasal smear, no polyps were removed. In all of this group the polyps were seen to shrink or remain constant in size under adequate allergic therapy. The remaining group consisted of 41 cases, or 65.4%, with large polyps, grades III and IV, obstructing the nasal passage, plus positive nasal smears. These were removed surgically. In 10, or 23.9% there was marked purulent infection associated with the allergy. In the other 31, or 76.1%, no infection was found.

In all cases in which the allergic therapy has been used in the followup treatment there has been an improvement, in the general condition of the nose. In 12, or 28.8%, there has been some return of the polypoid tissue. In only 5 has there been a necessity for further removal of tissue and in 2 of these there was a small polyp obstructing the frontal sinus ostium causing intense frontal headache which was relieved following removal. In 2 others the purulent infection has persisted.

Drug therapy is directed at combating the effects which histamine produces. The antihistaminic drugs are more commonly used today than any other group. They all show an antagonism for histamine, they do not have any effect on smooth muscle or on the peripheral vascular system. They do not effect histamine, but rather, they act as a blocking agent which prevents histamine from reaching the cell receptor mechanism. In these cases in which there is a true antigen antibody reaction, the histamine release is intracellular which is the probable reason for the failure of the antihistaminics to relieve symptoms.

Because of the great popularity of the antihistaminic drugs at present the sympathomimetic amines are not being used to the extent that they were formerly. It is well to remember that they are still of value when some of the newer drugs fail.

It should be pointed out that prolonged use of drugs may render them less effective by the patient building a tolerance to them or by producing a damaging effect on the tissues. Also, that in some instances, drugs produce sensitivity reactions.

In most instances adequate desensitization therapy and the discriminate use of drug therapy will produce gratifying results in patients with allergic disease of the nose and paranasal sinuses.

CONCLUSIONS

1. Allergy is an important phase of rhinology.
2. Histamine release is responsible for allergic symptoms.
3. Adequate history, physical examination, cytology of nasal secretions and skin tests are necessary for a diagnosis of allergy.
4. Seasonal allergic rhinitis is due to pollen sensitivity.
5. Small optimum dosage technique as recommended by Hansel is used.
6. Careful use of antihistaminic and sympathomimetic drugs are of value in treatment.

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Some Common Pediatric Accidents

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"There sat in a window a certain young man named Eutychus, being fallen into a deep sleep; and as Paul was long preaching, he sunk down with sleep, and fell from the third loft, and was taken up dead."

This quotation from the Bible is one of the first accidents recorded in our literature. When we read a headline today of a toddler falling through an unlatched screen on a third floor it is almost a duplication with the date line changed a few centuries.

What is the reason for the lack of "talk appeal" concerning the subject of accidents? If the title of this paper had been announced as a new vaccine for poliomyelitis, there wouldn't have been standing room, and yet accidents in Illinois in 1946-49 killed 10 times as many children as did polio and it crippled more children too.

Some of us will remember that 20 years ago, back in the early thirties, talks about polio were poorly attended because we were not seeing as many cases as we do now. But now poliomyelitis plays to a packed house especially if there is the possibility of anything new. Perhaps now the increasing relative importance of accidents in medical practice may stimulate a similar awakening of interest in our role as doctors both in care and prevention.

Now, before I get on to specific pediatric accidents, let me say a few words about accidents in general. I know that statistics are boring and you've all heard figures about accidents, but they are so startling that they bear repeating. First, let us always keep this fact in mind, that accidents are the number one killer between the ages of 1 to 25.

Accident death rates have decreased, but not nearly as much as the rates for many diseases.

In 1930 accidents were the third cause of death. In 1950 accidents were the first cause of death.

Not so many years ago the prevention of disease was thought of as either vaccination against small pox or something to do with public health measures in an epidemic. Today it is assumed that we will spend a great deal of our time preventing disease through inoculations, drugs and advice. Therefore, in discussing the various accidents encountered in pediatric practice, I shall continue this point of view stressing the preventive aspects rather than treatment.

There are a number of fundamental problems that make accident prevention much more difficult than disease prevention. When we go after a disease we can wage all out war against a germ. This is like the modern concept of "hot or shooting war" where everyone is mobilized against diphtheria, pneumonia or even polio. But accident prevention is more like a "cold war". It drags on and on; we don't always know who our enemy is, and we don't always know whether our enemy is actually at war with us or not. Above all we are sometimes pitted against our fellow man and even against some fundamental characteristics of human nature.

In the first place we are not really fighting against the things which cause accidents. It is important for people to realize that our world is full of objects and forces which in themselves

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are neither friendly nor unfriendly, neither safe nor unsafe. "The total depravity of inanimate things" as exemplificd by the "elusiveness of soap, the knottiness of strings, the transitory nature of buttons. . ." has furnished the subject for an amusing essay, but actually we attach no blame to things for the qualities which give them the power to exasperate or harm us. If we slip on the elusive soap, or the baby finds and chokes on the missing button, we do not blame the soap for being slippery or thc button for being small enough to go into the baby's mouth. In most accidents, we find somewhere along the line the human touch operating as a known or unknown factor. And so in safety education it is necessary to correlate both elements in the accident picture — human nature, and the nature of the things and forces with which human beings come in contact.

Very early in life the child begins to learn the nature of things and their uses — that knives are sharp, for example, and are useful for cutting his bread. Sharpness makes a knife as effective in cutting fingers as in cutting bread. The child learns that it is the way in which he handles the knife which makes it useful or harmful to him.

In evaluating the human element, we must realize that of all living creatures, human beings alone have developed the ability to think, reason, and remember. This faculty makes them immensely more adaptable than other living creatures. While this mental adaptability and its corollaries, inventiveness and dexterity, have made possible our astounding progress, they have carried with them a hidden hazard.

It has been pointed out that human beings are the only living creatures who have "taken a chance. We left the shelter of the trees and the protection of the caves; we played with fire; we crossed the perilous seas; we have dared to leave the earth." It is this characteristic of human nature that adds to the dilemma in safety education. Feats of heroism, thrilling adventures, even scientific research and exploration, are appealing, especially in youth, for the very reason that they often involve taking a sporting chance. This human characteristic undoubtedly poses a major difficulty, and let me say in passing that the only way to counteract it is to use constructively thc craving for excitement and the love of adventure which seem at first sight to exert a pull in the opposite direction from the objective of safety education. For youngsters a distinction is made between "good adventures" and "bad adventures". For older boys and girls emphasis is laid on the stupidity of spoiling a good time, or of allowing one's self to be taken out of the running, temporarily or permanently, for lack of know-how in doing things, or for want of knowing or respecting the nature of the things and forces with which one deals. In all accident prevention we nced to weigh these fundamental factors of thc neutral quality of the inanimate factor of most accidents, our need to evaluate the human role in learning to use safely these inanimate objects, our fundamental drive for change, excitement and taking a chance and the element of boredom in waging a cold war against accidents.

Statistically, what is the typical, ie, most common accident in childhood? According to a survey made in 1941 by Metropolitan Life Insurance Company a typical accident can be described as follows: "The victim received cuts of his legs as a result of a fall on a level surface against a tool, (or household furnishings) while he was walking (or running), in the dining or kitchen quarters of his home". Now obviously we can't avoid all such accidents as these, but it seems to me that about the only way we can work to lessen these "typical" accidents is by education. Who must be educated?

In 1948 the American Academy of Pediatrics put on a campaign to educate the doctor regarding accident prevention. I'm afraid most of us didn't pay enough attention to it and we have probably done very little about it since. First, the general practitioner and then the pediatrician are best able to educate the parents of the toddler, who is the most accident prone individual. We are often very close to the parents of our one year old patients and that is the time when we should start our campaign. There are many ways in which we can sow the educational seeds among our patients and although results are not immediately apparent every bit of propaganda is bound to help. The least we can do is to talk to parents and bring the problem to their attention. Then we can give them pamphlets which can be obtained from the Safety Council or the Metropolitan Life Insurance Company. Edward Press has suggested that a home safety check list be

given to parents about the time the child is 8 months old. Such a list could be filled out by the mother and discussed with her at the following visit. In addition we can prepare mothers for certain developmental periods which can be dangerous. For example, most mothers don't know when to expect their first child to be able to turn over, roll off a bed, table or bathinette. Proper preparation might save baby and mother from a frightening experience. Dietrich points out that we must give the young infant 100% protection, then we must gradually substitute learning experiences for this protection. It has been said the 6 year old is about 75% independent and we can give him only 25% protection. Therefore the parents must have replaced the 75% of the protection they gave him thru education as to the dangers about him and ways of meeting and avoiding these dangers. Thus, if we ourselves are accident conscious, we can impress the parents, who in turn can help to educate the child.

Turning again to fatal accidents we see the causes of death in the preschool child. Considering first the leading cause of accidental death, the motor vehicle, we see how many of these children are killed by being run over or hit as contrasted with those killed while riding in a car. We know that most of our patients who meet with an auto accident aren't killed, but the statistics are startling. There are 12,000 children killed annually and for every one of these, 6 go to the hospital and 2½ are permanently injured. There is no need to dwell on the treatment of the fractures, lacerations, internal injuries, etc., but pediatrics can make a contribution in prevention. Actually pediatrics is the very foundation stone of accident prevention, because, as mentioned above, we have access to the parent and the child at the beginning of life when patterns are being learned. I'm sure that we all realize our responsibility, for example in guiding the child's psychological development, but how often do we think of the fact that we can help thru our educational program with the mother to set the pattern for the child's accident prevention program for the rest of his life, in the home, in school, as a teen age driver and later when subjected to occupational hazards.

Another frequent type of accident seen by all of us is the burn. Obviously, burns vary from the little ones that parents treat to the severe ones that cause 28% of accident fatalities in the group, 1-4 years. This group ranks second only to transportation fatalities. There are almost as many treatments for burns as there are burns, therefore I shall not attempt to discuss or evaluate them here. Some burns result from the actions of other people, such as spilt liquids or burning houses, but probably most are caused by the individual's own mistake. Therefore, we must come back to personal education in our campaign to prevent this type of accident. In the preschool age the Mother must strike a balance between stifling the child's natural curosity and at the same time restrain his exploration of stoves, matches, electric light plugs, etc.

Statistically, drownings come next, and while we don't see many in our individual practices, as doctors we can make a community contribution in this area. We can urge that our fire and police departments have proper equipment and training and that proper supervision of public bathing facilities be maintained.

Next, I must say something about falls. It seems to me that I see (or at least hear about them on the phone) more injuries due to falls than anything else. In this connection we must remember that minor falls and injuries are of definite educational value and a certain amount of pain is a good teacher. Personally I never cease to marvel at the individual variations in relation to falls. A small tumble will result in a broken bone for one child while another can fall a great distance without harm. To my mind no one has very satisfactorily explained this. Right here is a good place to bring up the problem of accident proneness. Here there are 2 groups of factors operating. First, there are the physical; vision, hearing, neuromuscular coordination, etc. Second, naturally there are the emotional factors. So far, psychologists have been unable to devise tests for accident proneness, though they have tried. Much needs to be learned about how the emotional home situation is important in determining accident proneness and even more so in developing the child's accident prevention program. The parent must steer a middle course between over-protection and indifference, just as the doctor must steer a course between frightening parents about acci-

dents and indifference to the problem. When a child senses his parents' love and affeetion and realizes that they will try to prevent his being hurt it should increase his sense of seeurity. Dietrieh has brought up the problem of diseipline in this conneetion which is as "neeessary to the ehild's happiness as to his life. Due to recent psychologieal fads many ehildren have been deprived of the physieal and emotional security that rests on mild, eonsistent, and logieal discipline".

Then there is a type of aceident proneness that seems to eome to the teen ager, especially to the inseeure or negativistic boy or girl who must "show off" to his colleagues, particularly when he has just been placed in controi of that most lethal of all weapons, the automobile. Here is a field where the mental hygiene elinic should be able to help and some cities have developed "accident clinies" for the prevention and study of accidents. The driving classes being developed in our high sehools seem to be doing a good job of prevention in this area too.

Poisonings in small children arise with unexpected suddenness in all our practiees. Aside from general measures, the treatment depends on the specifie nature of the poison (if you ean find out what it was). Personally I have to keep a good reference book handy. As for prevention, here the physieian can do something specific in the way of warnings and instruetions to parents regarding drugs and household chemicals. We can also take precautions about the drugs we send into the home.

Time does not permit a lengthy discussion of all the many objects and situations that cause accidents to children. As a matter of faet, this multiplicity of eauses is one the difficulties in aeeident prevention because neither patient, parent nor doetor can always remember all the hazards. So far, I have emphasized the things we physieians can do in our personal relationships with our patients, but we must remember that we should also play an active part in safety programs in our eommunities in cooperation with the many ageneies interested in child safety.

In closing, let me say that my only object in speaking to you today on this subject is to make you more accident conscious and to remind you that, percentagewise, you can save more lives through aceident prevention than in any other activity, beeause accidents kill more of our children than any other agent.

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EMERGENCY ANESTHESIA

A word of caution regarding general anesthesia in the emergency case: Try to aseertain how long before injury or the onset of the aeute proeess the patient has had food. Invariably, gastric funetion stops after injury or with severe acute pain. It is very important that the stomaeh be emptied if undigested food is reasonably suspected to be present. More tragedies have oeeurred from the vomiting of food by the emergeney patient during some phase of an inhalation anesthetic, with aspiration into the lungs of an undetermined quantity of the material, than from any other factor due to anesthesia. It may be unkind to subject the injured or acutely ill patient with a full stomach to gastrie lavage or emesis but he will invariably vomit sooner or later and it is much better that it be done under controlled conditions. *Martin N. Anderson, M. D., Premedication and Choice of Anesthesia in the Surgical Patient. J.M.A. Alabama, Sept.* 1952.

Relating Biochemistry to Clinical Judgment

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The question sometimes arises as to what extent can one substitute laboratory data for clinical judgment. Also, to what extent can clinical experience concerning the usual course of a disease replace laboratory data. It is apparent that, in general, these two sources of information must be correlated and integrated with one another. It is only through such a combination that one can provide the best possible care for the patient.

There are many conditions in which one cannot intelligently regulate the therapy of a patient or provide an accurate diagnosis without considerable laboratory data. However, there are numerous clinical conditions that may give rise to the same laboratory findings. Hence, the clinical findings and history must be related to laboratory data in a given instance and the conclusion drawn must be consistant with *all* findings. There are certain aspects of disease in which the contributions made by biochemistry are most apparent and we may consider both the normal and the pathological variations of a few constituents of the body as a basis for relating the chemical value with the state of the patient.

It must be recognized somewhere along the line that one's understanding of the metabolic significance of any constituent is an important factor in determining how much worth laboratory data may have for the doctor in a given instance. Laboratory data in itself may contribute little or only serve to confuse the doctor, if not correctly interpreted and applied to the problem at hand.

Before taking up specific instances, it might be worthwhile to make a few comments regarding laboratory data in general. In the first place, the doctor must remember that laboratory data are not necessarily correct. It is necessary to be sure that only verifiable information shall enter into the reasoning of the physician. Abnormal results that may influence diagnosis or therapy should be thoroughly established and verified, particularly if they seem inconsistent with the rest of the laboratory data and clinical picture. It is surprising how often isolated determinations are used as a basis for diagnosis and medication without adequate verification. Not only do analytical errors occur, but there are errors in the collection and preservation of specimens. For example, chloride, carbon dioxide and pH values may be misleading if the blood is not collected correctly. Twenty-four hour urine specimens are very frequently unreliable as indicated by wide variations in creatinine excretion on successive days in the same individual. Furthermore, a specimen may have been collected at a time that was not representative of the patient's condition. For example, I remember an instance of a patient diagnosed as having adrenal insufficiency based upon laboratory data obtained shortly after a vasomotor collapse following the I. V. injection of diodrast. The blood obtained shortly after a period of shock was high in potassium, low in carbon dioxide, and had some elevation of non-protein nitrogen. The complaints which brought the patient to the hospital were fatigue, weakness, poor appetite, etc. The Kepler-Power water test gave a low A-value. The patient was given medication for adrenal insufficiency for one year. Readmis-

sion to the hospital at that time led to studies that established the presence of adequately functioning adrenals. The patient actually had some renal impairment secondary to pyelonephritis. This is an instance in which the laboratory data were accurate for the circumstance, but did not represent the steady state for that person. The circulatory collapse caused excessive tissue breakdown and chemical changes which might have been due to several different causes. One must interpret the data in the light of the circumstances under which it is obtained.

Let us superficially review some constituents of urine and blood that are determined frequently. For example, 17-ketosteroid concentration in the urine may aid in the diagnosis of Addison's disease, but there are a number of conditions that may give similarly low values — debility, pituitary and gonadal failure and myxedema will serve as illustrations. I recall a young man who was diagnosed and treated as having Addison's disease. He had a low 17-ketosteroid excretion as well as most of the other laboratory findings characteristic of this condition. There was no eosinopenia following the injection of epinephrine or single intramuscular injections of ACTH. The systolic blood pressure was low and there was a flat carbohydrate tolerance test. Positive proof of adrenal gland function was obtained by the daily intravenous administration of ACTH for ten days. This is an instance in which most of the laboratory data were combatible with a diagnosis of Addison's disease but certain items of the history were not characteristic of the condition.

Interpretation of the carbon dioxide combining capacity of the serum is sometimes confusing unless one relates the data to the clinical state of the patient. For example, a high plasma carbon dioxide content may occur in a metabolic alkalosis, (e.g. chloride loss) or a respiratory acidosis (secondary to emphysema). A low carbon dioxide combining capacity may result from a respiratory alkalosis (hyperventilation) such as may result from central irritation, or from a metabolic acidosis as in renal failure or uncontrolled diabetes mellitus. Usually the clinical state enables one to correctly interpret the laboratory result.

The concentration of serum sodium is an unsatisfactory guide of the sodium content of the body or of the extent to which it has been stored excessively or depleted. Changes in the hydration of the body usually precede changes in sodium concentration due to sodium retention or depletion. Serum sodium values are usually normal or low in sodium retention secondary to circulatory failure, and may be normal, low or high in dehydration, the value depending upon the relative amounts of salt and water in the body. The serum sodium concentration in adrenal cortical hyperfunction may be normal even though a marked retention of sodium occurs. This fact is another illustration that the unit concentration of this substance gives little or no evidence as to how its regulatory mechanism is functioning or whether the sodium balance of the body is positive or negative. In general, a primary sodium depletion will tend toward low serum values while a primary water loss will tend toward high values, but this rule is not invariable.

Constituents of greater constancy of concentration in body fluids are calcium, phosphate and potassium. The renal and endocrine mechanisms for regulating their concentration in blood plasma appear to be more sensitive than for sodium. Relatively large amounts of calcium, potassium and phosphate can be transferred from the gut or tissues and excreted in the urine without any significant change in their plasma concentration. Therefore, the unit concentration may give one little insight into bodily dynamics until the capacity of the body to adjust to abnormal states has been exceeded. For finer distinctions in the relative rates of ingress and egress of these constituents one must rely upon balance studies. It follows that high or low blood plasma concentrations of calcium, inorganic phosphorus or potassium will only occur when marked changes have been produced in their metabolism. The isolated laboratory finding may be of little value in directing the doctor to the basic defect in the body's function. However, given a recognized defect in the bodily processes, an abnormality in the plasma concentration of one of these constituents tells one much regarding the extent of the impairment.

One cannot rely on the electrocardiogram to demonstrate the exact nature of an electrolyte imbalance. For example, patients in uremia with normal serum potassium and low serum calcium values have electrocardiographic changes similar to those produced by a high serum po-

tassium and a normal calcium concentration.

There are many realms in which the physician must rely almost exclusively upon the laboratory for the information essential for diagnosis. Disturbances in endocrine function and errors in metabolism illustrate this statement. One is largely dependent on chemical findings for proof of the extent and nature of any metabolic defect. The degree and progress of renal impairment can best be followed by studying the composition of the blood in relation to the renal excretory load. Many other illustrations might be cited where laboratory findings may serve as an aid in diagnosis and treatment. It should be emphasized that laboratory data are of little or no value *unless the physician is thoroughly familiar with the physiological and pathological factors that may influence the concentration and metabolism of a given constituent.* The physician should always consider laboratory data in the light of the physiological circumstances under which they were obtained. It seems unlikely that there will ever be an adequate substitute for judgment and experience. However, the laboratory provides the exact details that enable the physician to practice quantitative medicine and to make fine shades of distinction regarding the functional alterations that occur in disease.

Dr. Richard J. Winzler, Professor of Biochemistry: I agree, of course, with Dr. Freeman on the main points of his discussion. Laboratory findings can be more confusing than helpful if they are not evaluated in the light of clinical observations.

I would like to raise another point that makes for confusion in the interpretation of laboratory findings — the reliability of the determination itself. A few years ago a series of replicate serum samples were sent to some thirty different laboratories in the same city for routine determination of calcium, glucose, NPN, etc. When the results of these unknowns were compiled, the discrepancy was disturbing, different laboratories reporting results varying by 300 to 400 percent for the same determination. The physicians practicing in this city could become very confused with such laboratory data. My question is "How important a practical problem is the question of the reliability of laboratory data?"

There is another question that I would like to raise. How many of the determinations that are sent to the laboratory are really valuable and necessary? It was noted that one of the two diabetic services operating in the same large west coast hospital had been requesting much more laboratory work than the other. Examination of the records over a period of several years revealed no differences in average hospital stay or in morbidity rates. The question as to whether the large laboratory load from one of these services was justified, therefore, was not answered. May I suggest, then with tongue in cheek, that a space be provided on laboratory forms for indicating the justification of a particular determination.

Dr. H. J. McDonald, Professor of Biochemistry, Stritch School of Medicine, Loyola University: Wide variations in the reports received when identical samples of a given material are sent to different laboratories are often only an indication that many of the persons engaged in clinical chemical laboratory work have not received sufficient training for the job at hand. When we realize that it is possible for a high school graduate, on the completion of a course of a few months duration in a proprietary school for the training of laboratory technicians, to secure employment involving the carrying out of clinical chemical procedures, — the validity of such experimental work is certainly questionable. Many of these people, I am sure, could not properly define a one molar solution. It is not biochemistry, *per se,* which is on trial in such cases. The poor showing in laboratory determinations is here simply due to poorly prepared laboratory technicians. If only laboratories where the work is in charge of persons properly trained in chemistry were investigated, the results would be much better.

Dr. Robert M. Kark, Professor of Medicine: One problem of laboratory tests in relation to the clinical practice of medicine is that each test has limitations as well as usefulness. Although most physicians are aware of the usefulness of tests, few recognize their limitations, with regard to methodology and interpretation. Not only is it important for the physician to recognize that technical difficulties or poor technique may give him incorrect data but he must realize that his interpretation of the data may not be valid because of present limitations of knowledge. For example, it is now becoming clear that measurements of electrolytes, such as sodium and potas-

sium, in plasma may not reflect what is happening within the cell.

Whenever we develop new laboratory tests we are prone to use them in clinical practice without knowing much about their variation in health. This is dangerous because in our ignorance we may diagnose disease where none exists. For example, twenty years ago when our knowledge of variation in electrocardiographs was not profound, physicians produced many cardiac invalids because a "normal" electrocardiograph was thought to be "abnormal." At present we are in danger of making invalids through wrong interpretation of biochemical tests because in many instances we have not yet collected enough data on physiological variations in health to know what the test means. For example, we all recognize in 1953 that creatinine/uric acid ratios are useless in the diagnosis of adrenal dysfunction but in 1950 many of us put great stock in these ratios. It is also deplorable that some physicians neglect painstaking, thorough clinical examination of the patient, in favor of quick results obtained from a battery of laboratory tests. They hope to pull the diagnosis out of a hat like a magician. Unfortunately, this practice — or malpractice — seems to be increasing. In general, if the biochemical results do not fit in with the clinical picture, one should repeat the tests and if there is still doubt in the clinician's mind, he should, more often than not, rely on his clinical judgment rather than on the results obtained from the laboratory.

Errors and Failures in Gallbladder Surgery

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The surgery of gallbladder disease has been developed to the point where the risk is not far removed from the nearly negligible risk of appendectomy so far as operative mortality is concerned[4,5]. But the failure satisfactorily to relieve or to ameliorate the symptoms of a variable proportion of patients presents a continued challenge.

Diagnostic Errors.—One outstanding defection has been the selection of the patient. Removal of a stoneless gallbladder is more likely to fail than to succeed in improvement of symptoms. Surgical gallbladder disease, with few exceptions, is calculous gallbladder disease.

Certain pitfalls in differential diagnosis should be mentioned. Clear-cut gallbladder colic, with or without characteristic antecedent dyspepsia, is the commonest indication for surgery. The current emphasis on early operation in acute cholecystitis decreases the opportunity for leisurely study. Prior recognition of gallstones by laparotomy for other disease, or by cholecystography, adds conclusive evidence in many cases. Nevertheless in a large share of cases, more complete diagnostic studies are in order, as gallbladder symptoms may so readily be mimicked by unrelated disease elsewhere. Careful anamnesis alone may prevent diagnostic error. The surgeon who accepts the responsibility for operation should review the history with the patient so that therewith he can correlate the subsequent operative findings and be in a better position to judge the extent of operation that is required.

Variants of angina pectoris cannot always be ruled out by history nor examination, and, indeed, electrocardiography may be inconclusive. Barium studies of the gastrointestinal tract may reveal esophageal hiatus hernia, cardiospasm, or peptic ulcer and pylorospasm, though ulcer is not uncommonly present concommitantly with gallstones. Spastic colitis or colonic spasm associated with diverticulitis or incompletely obstructing neoplasm must be given consideration. An increasing awareness of the serum amylase test has tended to decrease surgical intervention in acute interstitial pancreatitis; tumors of the

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head of the pancreas or ampulla of Vater may occasionally be suspected by fluoroscopy.

Radicular pain from vertebral osteo-arthritis, protruded disc or spinal cord tumor can confuse the picture. Basilar pneumonia or diaphragmatic pleurisy, likewise, may in the early stage, simulate acute right upper abdominal pathology. Incarcerated epigastric or umbilical herniae may not be obvious in the obese abdomen. Diaphragmatic parasternal hernia should not be overlooked.

Hepatitis, with or without jaundice, is often mistaken for primary gallbladder disease, and liver function tests may be required for differentiation. The cirrhoses may require subtle differentiation from biliary tract disease.

Not only failure to perform, but also failure properly to judge diagnostic procedures may lead to unnecessary surgery and failure. Nonvisualization of the gallbladder may be due to improper preparation of the patient, vomiting of the dye or rapid evacuation of the dye by diarrhea. Cholecystography too soon after an acute gallbladder attack may incriminate an organ that could concentrte adequately after recovery. Rarely a pigmented mole may cast a shadow suggestive of a calculus. Calcification in lymph nodes or costal cartilages may cause opacities overlying the gallbladder. Superimposed colonic gas forms a frequently misleading shadow. A right renal stone may be mistaken for an opaque gallstone unless pyelography or lateral cholecystograms are used.

Therapeutic Errors.—Errors in treatment may as commonly be due to acts of omission as those of commission. Rarely would it be advisable to remove a gallbladder for chronic non-calculous disease without a thorough test of proper medical therapy. And, by the same token, to deny a patient surgical relief when attacks are repeated is only to welcome the complicating sequelae that can increase the morbidity and mortality of medical treatment. Neglected gallbladder disease is a forerunner of common duct disease, stasis, dilatation, cholangitis, biliary cirrhosis, jaundice and the occasional development of malignant neoplastic changes.

The risk will be minimized if the patient can be brought to surgery in optimum condition, and the details of sound preoperative management should seldom be omitted. Prior to operations of election, the malnourished patient should be prepared by proper diet to overcome protein and vitamin deficiencies; on the contrary, reduction of weight from the obese may lessen the operative risk. Diabetes, so commonly present in conjunction with biliary tract disease, must be well controlled. The hypoprothrombinemia associated with obstructive jaundice may be easily correctible with the use of parenteral vitamin K.

In emergency operations the correction of dehydration and electrolyte imbalance should precede surgery. Blood for transfusion should be available. The stomach should be emptied by suction, and the tube can be left inlying during and after surgery.

Certain omissions of a technical nature at the time of operation may hinder a successful result. The operation of cholecystectomy may be considered incomplete if, as occasionally occurs, the cystic duct is clamped and ligated without adequate visualization, and a segment of the ampulla or an enlarged cystic duct, possibly containing stones or debris, is left in situ possibly to require reoperation for removal. Incomplete investigation of the biliary and associated systems may result in overlooked stones in the common duct, acute or chronic pancreatitis, tumors of the pancreas or ampulla of Vater, fibrosis of the sphincter of Oddi, anomalies such as double gallbladder, or associated disease such as duodenal peptic ulcer. Failure correctly to recognize common duct pathology and to correlate the findings with the history so as to prompt exploration of the duct is a chief cause of recurrent symptoms. The common duct may be explored in as high as 50% of cases by some surgeons, and stones in the duct are found in 25-40% of the duct explorations[2,5,9]. Common indications for choledochostomy are:

1. Palpable stones in common or hepatic ducts.
2. History or presence of jaundice not adequately explained by pressure on the duct from enlarged gallbladder or associated lymph glands.
3. Dilatation of common duct; thickening and opacity of duct wall.
4. Enlarged cystic duct.
5. Presence of multiple bird-shot calculi in gallbladder; a cystic duct of small caliber in such cases may justifiably lead the surgeon to assume that any stone passing through it will be small enough to pass into the duodenum; there may be some gamble in this viewpoint.

6. Small, shrunken gallbladder; our experience agrees with Cattell's[2] that stones or sludge in the common duct are likely to be present when the gallbladder has reached this advanced state of disease. In addition, we find the removal of these gallbladders to be technically more difficult because of the retraction of the scarred tissues about the artery and duct causing a greater danger of injury to the right hepatic artery or duct.
7. Repeated attacks of cholangitis with chills, fever, jaundice.
8. Cloudy bile or "ground pepper" particles in bile issuing from cystic duct stump if inspected prior to ligation, or in bile aspirated from the common duct.

Cholecystostomy is a second choice operation except in poor risk patients, where simple removal of calculi and drainage becomes the first choice.

Whereas the errors of omission are predominantly faults of surgical judgement, the errors of commission are, in the main, due to faulty technique. Inadequate respect for the operation of cholecystectomy is the fundamental reason for most of these errors, many of them tragic. Failure to respect the operation begets a disinterest in the anatomy of the ductal system and of the vascular pattern which is so commonly the site of anomalous development. Inadequate exposure due to the choice or extent of incision may prevent recognition of anatomical structures. Without adequate exposure of the cystic vessels, the cystic duct and its junction with the hepatic duct, any of several unplanned events is apt to occur. Traction during ligation of the cystic duct may result in tenting of the common duct and its inclusion in ligature or clamp. Hemorrhage from a poorly visualized and uncontrolled cystic artery with attendant blind application of hemostatic forceps easily results in crushing or ligation of the hepatic duct. Without adequate visualization of an edematous or scarred cystic duct a segment of the wall of the common duct may be excised, or, indeed, the duct may be unwittingly divided. The treatment of operative strictures of the common duct is not within the scope of this paper save to suggest that there is no treatment equal to the prevention of stricture by avoidance of trauma to the duct or by recognition of trauma and primary repair at the time of injury.

Ligation of the cystic duct close to the common duct under direct vision, without the use of clamps, prior to its division satisfies us as the safest technique. The cystic artery is dissected out separately and, when one is satisfied as to its identity, it may be ligated and divided much closer to the gallbladder than may the cystic duct. Double cystic arteries occur in as high as 25% of cases and the great variation in pattern of the cystic artery demands vigilance, else the right hepatic artery may be ligated[1,3,6]. This accident, always considered as a fatal error in the human, but seldom reported, may in the experimental animal be ameliorated by high dosage of penicillin to prevent clostridial infection in the anemic liver[7] and may prove to be less disastrous in the human than formerly believed. Should the cystic duct contain small calculi, care must be exercised that calculi or fragments are not forced into the common duct, where they may remain as a nidus and require reoperation.

Insecure ligation of the cystic duct can result in serious or fatal bile peritonitis. Similar leakage has occurred from puncture wounds of the common duct following needle aspiration and inspection of the bile. Following removal of the gallbladder, its bed in the liver and the exposed structures of the gastrohepatic ligament should be reperitonealized to minimize adherence of the pylorus, duodenum or colon in the healing period. We will not take issue with those who prefer not to make use of a drain following the operation, other than to state that the occasional discharge of bile that is not expected from a wound in the first day or so after operation suggests that biliary radicles may be unwittingly opened in the gallbladder bed, and the practice of draining the operative site may occasionally prevent or minimize bile peritonitis or subphrenic and subhepatic bile collections.

Gallbladder surgery is being extended to include more common duct surgery by all surgeons who conscientiously review their own or others' followup series. Recognition and division of the fibrotic sphincter of Oddi by the transduodenal approach is increasingly frequent. The operative cholangiogram has been in use by many surgeons for a long enough time to prove its value in minimizing overlooked common duct stones. The

lithophone is not in widespread use but may have its rightful place and is certainly indicative of a general effort to increase the success of the primary operation. Manometry of the ductal system is still in the experimental stage and seems a cumbersome adjunct to surgery, but greater understanding of the physiology of the ducts and ampullary sphincter system is sure to follow its acceptance[8].

Regardless of the conscientious application of these many principles and aids in the treatment of choledocholithiasis, the postoperative cholangiogram before withdrawal of the T-tube all too frequently shows calculi or fragments remaining in the duct. Most of these, no doubt, were overlooked in some manner, but surely many of them come down from the inaccessible intrahepatic ducts, which may actually be the site of origin. Modifications of Pribram's method of dissolving these calculi by ether injections into the T-tube are useful in avoiding further operative intervention[10].

In summary, the common errors or failures in gallbladder surgery are reviewed. Errors in diagnosis account for a considerable proportion of these. Errors in therapy are: (1) acts of omission, principally errors in surgical judgement, and (2) acts of commission, basically technical faults.

An increasing awareness of the coincidence of associated common duct disease is essential to improvement in surgery of the gallbladder.

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BRONCHOLITHIASIS

Calcified lymph nodes are seen at the pulmonary vascular roots on many chest x-ray films. When the calcific nucleus of one of these nodes migrates through the adjoining bronchial wall toward the lumen, it produces effects which become clinically apparent. The wandering calculus is called a broncholith and the disease which it produces is termed broncholithiasis. This paper will be concerned with the principal effects of these stones upon the bronchi, lungs, and pleura. It is now evident that broncholithiasis is not an uncommon disease and that its early recognition is important if prolonged bronchial obstruction leading to pulmonary and pleura suppuration is to be avoided. With prompt relief of bronchostenosis, the morbidity and mortality associated with broncholithiasis should be reduced and the indications for pulmonary resection, which may be difficult and extensive in this disease, should become less frequent. *Morton M. Ziskind, M.D., Effects of Calcified Lymph Nodes Perforating The Bronchial Tree. New Orleans M. & S. J. Sept.* 1952.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Brachial Plexus Injuries

Associated with the Traumatic Shoulder Joint

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In a recent five year review (1946-1950), of brachial plexus injuries in adults at the Cook County Hospital, Chicago, Illinois, it was significantly noted that approximately 1.4% of these lesions were associated with a traumatic shoulder joint lesion. The associated traumatic lesions were acute and chronic dislocations of the shoulder, fracture of the shoulder (tuberosity, anatomical neck), and injuries of the clavicle. (Table 1). We have also observed during the past three years, three cases of brachial plexus lesions in children associated with a traumatic shoulder and elbow joint. Because of the rarity of this latter group, case histories will be described in detail. (Table 2).

The adult cases in this series were observed in the various wards of the Cook County Hospital. Besides the eight cases of brachial plexus lesions associated with the traumatic shoulder joint, there were seventeen cases of brachial plexus injuries caused by other methods of injury. (Table 3). Both groups of cases were originally seen in the emergency outpatient department, and were subsequently transferred to the various wards, depending on the examining physician. Some cases were sent to the neurosurgical department, while others were sent to the neuro-

TABLE 1

BRACHIAL PLEXUS LESIONS ASSOCIATED WITH "THE TRAUMATIC SHOULDER" (1946-1950 Inc.)

ETIOLOGY	NO. OF CASES	RESULT
Acute Dislocation, Shoulder	3	Good—2 Poor—1
Chronic Dislocation, Shoulder	2	Poor
Fracture Dislocation, Shoulder	1	Good
Fracture Tuberosity, Humerus	1	Fair
Fracture Clavicle (Old)	1	Good

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TABLE 2

BRACHIAL PLEXUS LESIONS IN CHILDREN

ETIOLOGY	NO. OF CASES	ASSOCIATED BONE LESION	NERVE LESION	END RESULTS
Automobile Accident	2	Acromioclavicular separation with fracture of the humeral condyle	C8 & T1	Partial recovery
Birth Trauma	1	Fracture Clavicle-(?)	C5 - T1	Complete recovery

logical, orthopedic, and surgical wards. As seen from Table 1, three brachial plexus lesions were associated with an acute dislocation of the shoulder; two cases entered the hospital with chronic dislocations of the shoulder; one was associated with an acute fracture dislocation of the shoulder; one patient with a fracture tuberosity of the humerus; while one patient entered the hospital with an old fracture of the clavicle, with marked callus formation and secondary pressure of the brachial plexus.

General Pathological Considerations and Findings: Unlike war injuries of the brachial plexus, civilian injuries are generally, of the traction or the direct traumatic type. The original force causing a dislocation or fracture of the shoulder joint can also produce, by traction on the neck and shoulder, attenuation injuries or tears of the nerve roots, trunks, cords, or peripheral nerves. Likewise, a dislocation of the shoulder joint at the infraglenoid area can result in a direct injury to the peripheral nerves of the brachial plexus; immediately below the clavicle. The acute dislocation of the shoulder, associated with brachial plexus injuries, can be detected easily by the general appearance of the upper extremity, associated with neurological, neurovascular, or trophic disturbances. Sensory involvement is generally diffuse, and does not follow a definite dermatome pattern. Motor function loss is more extensive immediately after the injury; but recovery can occur to a variable extent, with immediate and proper treatment. Traction or direct traumatic injuries to the plexus associated with the acute type of injury (dislocation or fracture of the shoulder joint), is usually an isolated injury; without involvement to the lungs, large blood vessels, or deep neck structures. Although some recovery may be seen early, a residual paralysis frequently results from the marked traumatic edema, hemorrhage, or injury to the fascia, ligaments, muscles, or nerves.

TABLE 3

OTHER ETIOLOGICAL FACTORS

ETIOLOGY	NO. OF CASES
Gunshot Wound, Neck	5
Stab Wound, Neck	5
Trauma Soft Tissues, Neck	3
Scalenus Anticus Syndrome	2
Crutch Palsy	1
"Sleep Compression" Syndrome	1

The two cases of chronic dislocation of the shoulder associated with brachial plexus injury, presented marked trophic changes of the extremity; with patchy sensory loss, and almost complete loss of motor function. The involved joints were stiff, fibrotic, and painful on passive motion. In one case, an exploratory operation of the brachial plexus area revealed a marked fibrosis of the cords, with perineural adhesions, and scarring throughout the base of the neck. Pressure phenomena seen in an old fracture of the clavicle with brachial plexus pressure were relieved by careful resection of the large vicious callus deposited at the posterior aspect of the clavicle. No other operative procedures were done in this group of cases.

In the three cases of brachial plexus lesions in children (Table 2), the lower cord was involved in all. As seen from this table, two resulted from serious automobile accidents; the children being catapulted from the rear door

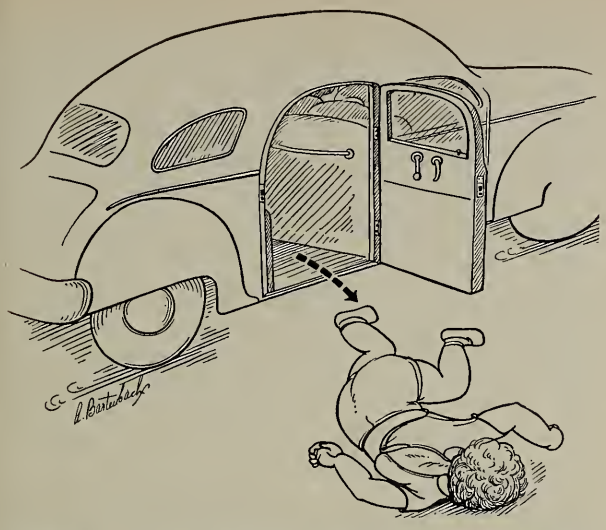


Figure 1 — Child thrown from rear of moving automobile, causing traction injury to brachial plexus.

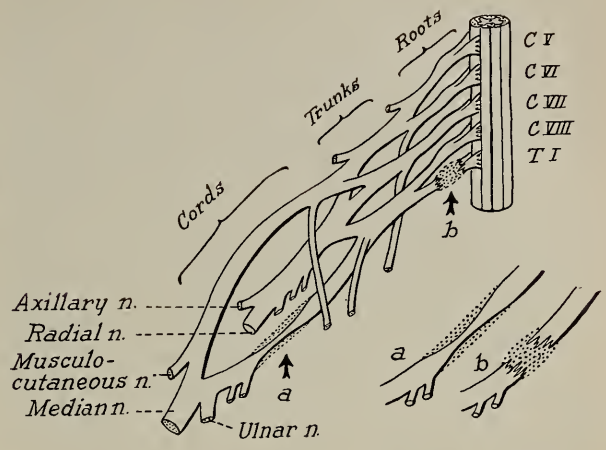


Figure 2 — a-Attenuation injury of the medial cord of the brachial plexus.
2—b-Tear of the first thoracic nerve root in certain brachial plexus injuries.

of a moving automobile (Figure 1), causing a severe traction tear of the lower portion of the brachial plexus. This injury was associated in both cases with acromioclavicular separations and fractures of the humeral condyle. A compound injury in the region of the shoulder joint in one case, was treated immediately by suture of the facia and the insertion of a stainless steel wire for the acromioclavicular separation. The third case was an infant with a doubtful injury to the acromioclavicular area and clavicular area. Marked hyperostosis of the clavicle and secondary pressure of the brachial plexus occurred. Complete recovery took place, however, in this particular case; while the two cases resulting from marked traction of the plexus following the automobile injury, resulted in permanent residual paralysis from involvement of the lower roots of the brachial plexus. The pathology in the latter group, it appeared, was a tear of the lower roots or lower trunk (Figure 2- a, b.).

Adult Case Reports (*Table* 1).—In the adult group of cases, three were female patients, five were male. All acute cases (5), were treated conservatively; while the chronic cases were treated surgically. Two required amputation for the severe trophic extremity disturbances; associated with a useless, dangling extremity. The third case required removal of the large vicious callus at the posterior aspect of the clavicle.

Brief histories are herewith recorded: Case No. 1. Mrs. E. K., female, aged sixty, suffered a dislocation of the right shoulder joint when struck by an automobile. Immediate examination at the hospital revealed a lesion of the seventh and eighth cervical nerve roots, as well as the first thoracic nerve root (lower cord lesion). Temporary loss of function of the hand (intrinsic muscles), was noted; as well as weakness of the wrist flexors and extensors. Immediate reduction of the shoulder was done — the patient placed in a soft tissue bandage — the wrist "cocked up". Physical therapy was instituted the third day, with galvanic stimulation being applied to the forearm and arm muscles. An excellent return of function within a short period of time occurred.

Case No. 2. Mr. J. G., male, aged sixty-one years, was admitted to the Cook County Hospital on February 10, 1949, with an acute dislocation of the shoulder joint. The patient complained of tingling and numbness of the extremity, with an inability to move the wrist and elbow joints. The dislocation was immediately reduced. Later, nutritional disturbances of the hand were noted (swelling, nail changes, and atrophy of the distal pulp of the fingers). After several weeks, during which time the modality of physical therapy was employed, marked atrophy of the supraspinatus, infraspinatus, and deltoid muscles occurred. The patient was followed in the clinic for three months. He refused further treatment, and was discharged with a diagnosis of residual paralysis of the extremity, based upon a brachial plexus injury.

Case No. 3. Mr. A. S., male, aged sixty-five years, was admitted to the Cook County Hospital on October 29, 1950, following a "beating up" at the hands of an assailant. X-rays revealed a subglenoid dislocation of the shoulder. Motions of the left hand were minimal, and loss of sensation was noted over the first, second, and third fingers on the palmar side. Three weeks later, there was improvement of sensation, and motor function returned to a considerable extent. Physical therapy was continued throughout this period. Six months later, the patient had an almost complete return of function. Residual muscle atrophy, from nonuse, of the shoulder muscles remained as the only visible sign of this injury.

Case No. 4. Mr. N. O., male, aged fifty-two years, was admitted to the Cook County Hospital on February 6, 1949, with a history of having been in an automobile accident some years before. The patient sustained fractures of both legs, as well as a dislocation of the right shoulder joint. A complete brachial plexus lesion was present (roots of fifth cervical nerves to the first thoracic nerves). Deformity of the shoulder, elbow, and wrist joints, had occurred. Motion was completely absent, and marked neurovascular phenomena were noted in the form of trophic ulcers (fingertips), edema, and shiny skin. There was, also, brittleness of the nails and scaling of the skin. The extremity was dangling and nonfunctional. An amputation at the upper sixth of the arm was done. Considerable relief was obtained. The patient returned to a part time occupation.

Case No. 5. Mr. J. E., aged sixty-eight, was admitted to the Cook County Hospital on June 4, 1947, with a total paralysis of the left upper extremity associated with a dislocation of the shoulder joint. This had occurred some years before when he was in an automobile accident. The entire extremity was useless, dangling, and continuously painful. Amputation at the shoulder joint level was done, with good healing of the surgical incision. The patient returned to a part time occupation.

Case No. 6. R. H., a female, aged seventy-three years, was admitted to the Cook County Hospital on August 5, 1950, with a diagnosis of a fracture dislocation of the shoulder joint. The fracture occurred at the anatomical neck of the humerus. Because of the associated brachial plexus involvement, surgical excision of the head of the humerus was done, and the arm immobilized in a spica plaster of paris cast. A partial return of function of the hand occurred; while the function of the flexor and extensor muscles of the forearm was minimal. Hypesthesia on the dorsum and palmar aspects of the hand and distal (one or two) thirds of the forearm decreased. There remained, however, a residual paralysis of the intrinsic muscles of the hand, with prehensile function loss, and limited flexion and extension of both wrists and elbow joints. Considerable atrophy of the shoulder remained.

Case No. 7. R. B., a twenty-seven year old female, was admitted to the hospital on October 10, 1949, with injuries to the pelvis and left femur and tibia. A fracture of the greater tuberosity of the shoulder had also occurred in this accident. There was an associated brachial plexus lesion confined to the seventh and eighth cervical roots, and the first thoracic nerve root, with intrinsic muscle atrophy of the hand, loss of flexion of the fingers, and partial loss of the hand flexors. Although the condition improved somewhat, a residual paralysis of the muscles continued in spite of treatment.

Case No. 8. Mr. S. O., aged fifty-two years, was admitted to the Cook County Hospital, with an old fracture of the middle third of the clavicle. There was a large, vicious callus noted at the fracture site. Marked weakness of the extremity, with loss of intrinsic muscle function of the hand, and patchy anesthesia over the dorsum of the thumb, occurred. The brachial plexus lesion was confined to cervical sixth and seventh nerve roots. Surgical excision of large callus was done, with marked improvement of the condition.

Brachial Plexus Lesions in Children: Three cases seen in children were of sufficient interest to warrant description in detail, inasmuch as traumatic lesions in this group (other than birth injuries), are rare.

Case No. 1. Baby C. M., a colored male infant, was admitted to the Cook County Hospital on June 22, 1952. The right arm was completely flail, and the head flexed to the right side, with marked muscle spasm (sternocleidomastoid, trapezius, and deltoid), causing the deformity. On stimulation, feeble function of the forearm flexors could be obtained, but extension was absent. Elbow function was also lost at the time

of admission. There was a history of trauma to the right shoulder and clavicular area several days before admission. X-rays revealed marked callus formation around the entire bone, simulating a Caffey's syndrome. X-rays taken of the ribs and long bones revealed some evidence of periosteal callus formation (of the ribs only). Local heat and analgesics were ordered. Two and one half months following this condition, an almost complete recovery had taken place. The infant had a return of function of the hand, elbow, and shoulder joint regions.

Case No. 2. C. S., a female, aged two years, was injured on September 24, 1950, when thrown precipitously from the rear door of an automobile (figure 1). The child sustained a laceration of the scalp, a fracture of the condyle of the humerus with displacement, and an acromioclavicular separation. She was unable to move her fingers, and had difficulty in flexing and extending the wrist joint. Sensory loss was present over the dorsum of the hand and finger area. The right pupil was smaller than the left, with narrowing of the palpebral fissure on this side. The deep reflexes were unobtainable, the forearm flexors were only of fair strength, and the carrying angle of the elbow was increased. Although the movement of the fingers improved with treatment, atrophy of the intrinsic muscles of the hand remained. A diagnosis of residual paraylsis of the brachial plexus (eighth cervical and first thoracic nerve lesion), was made. The patient was treated throughout her convalescence with an abduction splint, galvanic stimulation to muscles, massage and exercises. Two years after the injury, the same residual paralysis remained.

Case No. 3. W. B., aged four and one half years, was injured on April 17, 1949, when thrown from the rear door of a car "going sixty miles an hour" (Figure 1). The patient sustained a laceration of the left shoulder, an acromioclavicular joint separation, and a fracture of the condyle of the humerus. According to the father, "the whole left arm was almost torn from the shoulder, and it was hanging". Immediate surgery done by a local physician, who repaired the "branches of the brachial plexus", and sutured the aromioclavicular joint. Immediately after the injury, the left pupil was noticeably smaller than the right pupil. Two years later, however, this condition was absent. The child, seen by one of the authors (D.S.M.) two weeks after the injury, was treated by an abduction splint, with graduated physical therapy in the form of heat, massage, and exercises. Considerable return of function was noted, with however, a consistent loss of the deep reflexes and loss of vibratory sensation. A return of the upper portion of the brachial plexus innervation was noted. A diagnosis of injury to the seventh and eighth cervical nerve roots, and first thoracic nerve root was made. Three and one half years later, the condition remained unaltered.

Summary:—Brachial plexus lesions associated with a traumatic shoulder joint are not an infrequent complication. It is probable that a considerable number of transient brachial plexus injuries occur without detection by the busy traumatic surgeon, orthopedic surgeon, and surgeon. A very careful examination of the injured shoulder joint and nerve supply of the extremity is necessary to determine the question of brachial plexus injury. Motor and sensory loss should be carefully recorded, joint function examined and recorded, with particular attention being paid to the intrinsic muscles of the hand. Acute dislocations of the shoulders in adults cause brachial plexus injuries by direct trauma to the peripheral nerves, while brachial plexus injuries in children are generally due to severe stretching and traction of the plexus roots or in the latter group, (table 2), of the trunks. As noted, these cases are much more serious and produce residual disabling conditions. Furthermore, acute dislocations that remain untreated, may subsequently produce considerable scarring, adhesions, and secondary involvement of the brachial plexus. Depending upon the extent of involvement, treatment consists of vigorous and dynamic physical therapy, abduction splinting, and galvanic muscle stimulation. If these measures fail, amputation may be required. Serious neurovascular phenomena and trophic nerve changes may prevent joint arthrodesis or joint reconstruction operations. Injuries to the clavicle, as seen above, may produce marked and vicious callus formation, with secondary pressure on the brachial plexus. These large callus tumors can be easily removed, with total relief of pain and complete return of function.

Conclusions:—1. Brachial plexus lesions occasionally occur with dislocations of the shoulder

joint, fractures of the shoulder, or clavicular injuries.

2. Early treatment is imperative, and should consist of immediate reduction of the shoulder joint, and a careful evaluation of the peripheral nerves.

3. Re-examination is imperative, and good records are important to determine the progress of the condition.

4. Brachial plexus lesions should be treated by careful abduction splinting, galvanic muscle stimulation, active and passive motions of the joints.

5. In the presence of severe neurovascular complications, or those cases associated with severe trophic disturbances, amputation may be necessary.

6. Before amputation, however, every consideration should be given regarding the possibility of joint reconstruction or fusion operations.

7. Prophylactically, of course, doors of automobiles should be carefully locked in order to avoid the injuries in children described above.

THE ORIGIN OF COXSACKIE DISEASE

In the past several years we have added an entirely new group of virus agents to the growing research on the virus world, and it will take time to learn and assimilate the facts regarding this new group of virus diseases. Again, our imagination is stimulated and history is being made. With the discovery by Dalldorf and Sickles in October, 1947, of viruses pathogenic for suckling mice from the feces of two children of the town of Coxsackie, N. Y. there was uncovered an entirely new group of viruses known as the Coxsackie group. The two children, both paralyzed, were selected originally on clinical grounds as probable sources of the poliomyelitis virus. However, they were found to be infected with viruses antigenically and pathogenically different from the poliomyelitis virus. That the new virus had actually infected one of the patients was proved by the presence, in his convalescent serum, of neutralizing antibodies to the Coxsackie virus. Thus it was established that typical poliomyelitis might occur coincident with this previously unrecognized virus. The subsequent discovery that both original Coxsackie patients were infected as well with the poliomyelitis virus has reaffirmed the specificity of the poliomyelitis syndrome. *Editorial, The Coxsackie Group of Viruses and Their Component Human Disease Manifestations. Pennsylvania M.J. Dec.* 1952.

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Atherosclerotic Occlusion of Nutrient Branches of the Anterior Spinal Artery

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Atherosclerotic occlusion of nutrient branches to the spinal cord occurs at various levels of the anterior spinal artery. The cord tissues at or near the site of occlusion are infarcted and symptoms of cord injury specific for the level of infarction appear in the patient.

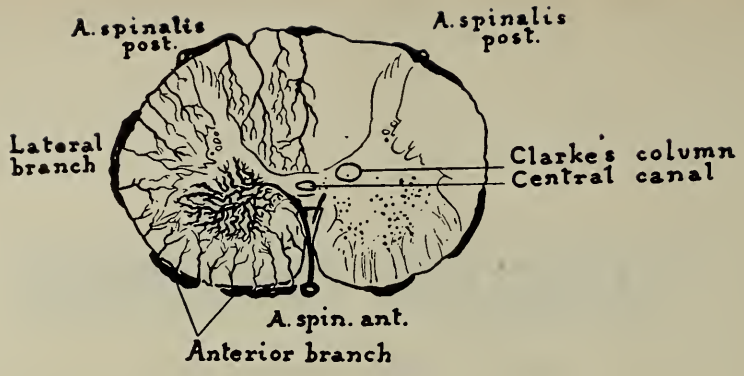
Arterial blood supply of the spinal cord.

Anterior spinal artery.—A small branch from the terminal portion of each right and left vertebral artery extends obliquely downward and medially over the ventral surface of the medulla oblongata. The paired arterial branches join at the level of the foramen magnum to form the anterior spinal artery. This artery extends along the anterior surface of the spinal cord and at the caudal end anastomoses with the two posterior spinal arteries. Through its long course the anterior spinal artery receives a supplemental blood supply through six or eight anterior radicle arteries given off by the aorta or its main branches at various levels of the spinal cord and which enter the spinal canal through the intervertebral foramina. The size of the anterior spinal artery varies at different levels. It is largest in the lumbar region, smaller in the upper cervical and lower thoracic levels, even smaller in the lower cervical and upper thoracic levels, and is least in the middle thoracic segments. The branches of the anterior spinal artery to the spinal cord are:

1. The sulco-commissural arteries, that extend into the anterior median fissure as far as the anterior commissure.
2. The anterior branches that spread through the pia over the surface of the anterior funiculus.
3. The lateral branches that lie in the pia and send penetrating branches to the white matter of the anterior and lateral funiculi.

Posterior spinal artery.—The two posterior spinal arteries begin their course similar to the anterior spinal artery as branches of the verte-

From the Henry Baird Favill Laboratory of St. Luke's Hospital, Chicago.



The vascular territories of the spinal cord in transverse section
Diagram 1.

bral artery. They are in the posterolateral sulci, lateral to the posterior roots and receive on the average eight posterior radicle arteries on each side as arterial reinforcements from the aortic blood stream. The posterior spinal arteries do not unite and they cover the entire length of the spinal cord as two separate vessels forming at their caudal end an anastomosis with the anterior spinal artery. Otherwise, the anterior and posterior spinal arteries do not communicate and remain as separate systems throughout. This makes possible a clinical differentiation of the symptoms caused by occlusion of the anterior and of the posterior spinal arteries.

The anterior spinal artery supplies the ventral two-thirds of the spinal cord including the anterior horns, the central grey matter, the anterior and lateral tracts, and the anterior and lateral pyramidal tracts of the white matter. The posterior spinal arteries supply only the posterior gray horns, the posterior white commissure and the posterior funiculi (See diagram 1).

The internal structure of the spinal cord.—The spinal cord has a supporting stroma, glia cells, nerve cells of the grey matter of the anterior and the posterior horns, and fiber tracts of the white matter relating the brain with the spinal cord both ways and interrelating different segments of the cord. These tracts are grouped into three major entities: the anterior, the lateral, and the posterior funiculi, each containing ascending and descending tracts.

The anterior funiculus contains with other structures:

1. The ascending ventral spino-thalamic tract, probably concerned with certain touch impulses whose fibers originate from cells in the posterior column, cross the anterior commissure and end in the thalamus; and
2. the descending direct pyramidal tract, concerned with voluntary movements.

The lateral funiculus contains essentially:

1. The ascending lateral spino-thalamic tract, conducting impulses of pain and temperature through fibers derived from cells in the dorsal column, which cross in the anterior commissure to the opposite lateral funiculus and terminate in the nucleus ventral postero-lateralis of the thalamus and thence are relayed to the cerebral cortex;
2. the descending crossed pyramidal tract conducting impulses from the the motor cortex to the motor centers of the spinal cord.

The posterior funiculus contains ascending tracts concerned with discriminatory sensation, such as sense of position of the limbs and of localization on the skin, of muscle tension, of joint movement, of vibration and also with muscular coordination.

Atherosclerosis.—Atherosclerosis usually affects large arteries such as the aorta and its main branches. In the cerebro-spinal system the cerebral arteries are frequently involved, much less often the spinal arteries. The most common lesion of atherosclerosis is a fibrous thickening with fatty changes of the intima and media, associated with secondary calcification. In Monckeberg's sclerosis the medium-sized arteries are affected. In arteriolar sclerosis the small peripheral arteries are usually affected. These changes consist of various types of hyperplastic

thickening of the vessels with consequent narrowing of the lumen.

Syndrome of the anterior spinal artery occlusion.—Occlusion of the anterior spinal artery is characterized by:

1. Paraplegia, of the flaccid type, due to the involvement of the grey matter of the anterior horns (lower motor neuron);
2. dissociated anesthesia of the syringomyelic type due to spinothalamic and commissural involvement (pathways for pain and temperature), with escape of the posterior columns (pathways for touch and deep sensibility);
3. disturbances of urination and defecation due to spinal shock in the first stage, and to direct involvement of the centers in the lumbo sacral region or involvement of the inhibitory fibers descending from the brain;
4. trophic disturbances, possibly due to softening of the Clarke's columns.

A clinical differentiation can be made of the level of the occlusion of the anterior spinal artery and the region of cord infarction on the basis of the clinical symptoms. These are pathognomonic for definite segments of the spinal cord. See Table I.

Regardless of the level of the occluding lesion in the spinal artery the changes in the spinal cord are those of necrosis of the region supplied by the occluded vessel and ascending and descending degeneration of the affected axons. Two reports have been published of atherosclerotic myelopathy with secondary syrinx formation. If the occlusion of the spinal artery is incomplete or only transient, the changes of the spinal cord are those of temporary ischemia associated with clinical symptoms of intermittent claudication of the thighs.

REPORT OF CASE

A white widow, aged 64 years, was readmitted to St. Luke's Hospital to the service of Dr. C. A. Johnson on June 8, 1951 and death occurred on November 10, 1951.

History: She was known to have hypertension and nephrosclerosis since 1946, mild diabetes since October, 1949 and numbness with tingling of the lower legs since 1947. In 1946 the Kahn test of the serum was positive and the Wasserman was weakly positive. In 1947 the Kahn test was negative and again in October 1949, but in February 1951 the Kahn test of the serum was doubtful, the Wasserman was negative and the VDRL test was positive. There was no definite history of antiluetic treatment. On February 19, 1951 she was admitted with a flaccid paraplegia and sensory disturbances of the legs up to the knees, of sudden

TABLE 1

SYNDROME OF ANTERIOR SPINAL ARTERY OCCLUSION

General Features below the level of the Medulla Oblongata:

Clinical Symptoms	Pathology
1. Atrophic, lower motor neuron, flaccid paralysis;	Necrosis of the motor neurons of the anterior horns.
2. Dissociated, level specific, anesthesia of the syringomyelic type;	Necrosis of the anterior commissure and of the spinothalmic tract (pain and temperature pathways) with intact posterior columns (touch and deep sensibility tracts).
3. Disturbances of urination and defecation;	Involvement of lumbo-sacral centers for urination and defecation and of cerebral fibers and inhibiting the bladder.
4. Trophic disturbances	Involvement of the Clarke's column.

Specific variations in the syndrome of anterior spinal artery occlusion:

Level of Infarct	Clinical Symptoms	Pathology
MEDULLA OBLONGATA	1. Contralateral pyramidal tract signs of the trunk and upper and lower extremities. 2. Contralateral dissociated anesthesia with loss of deep sensibility and touch and retention of pain and temperature sensibility. 3. Ipsilateral paralysis and atrophy of the tongue.	Ipsilateral necrosis of the pyramids; of the medial lemniscus with intact spinal lemniscus and ipsilateral necrosis of the hypoglossal nerve.
CERVICAL CORD	1. Upper motor neuron, spastic paralysis of lower extremities. 2. Atrophic, lower motor neuron flaccid paralysis of the upper extremities. 3. Bilateral Horner's syndrome.	Necrosis of the pyramidal tracts, motor neurons of anterior horns and of the ciliospinal bundle at C 8 and T 1.

onset and with disturbance of defecation and urination. According to the clinical record, she was in apparent good health when suddently she had an excruciating non-radiating pain in the lumbar region and realized that she would fall. She managed to get into a chair, from which she was taken to the hospital as a paraplegic. Her past history revealed that she had hysterectomy in 1934 for a pelvic tumor; hemorrhoidectomy in 1945; and bronchopneumonia in 1946. Her mother had diabetes and a pelvic tumor and died at the age of 66 from hypertensive heart disease; her father died in an accident at the age of 71 years. A sister was hypertensive, and a brother was diabetic.

Physical Examination: Her temperature, pulse and respiration were within normal limits, the blood pressure was 230/110 mm. of Hg. The physical examination was negative except for some degree of mental aberration and a sluggish reaction of the pupils to light. The following positive neurological findings were confined to the lower extremities. There was paralysis of both feet; the left leg and left thigh were weak, the right leg and thigh were slightly stronger. There was sensory loss to pain in both feet tapering off at the ankles, but at a little higher level on the left. Vibratory sense was decreased in the left foot. The Achilles tendon reflexes were absent bilaterally, the right knee jerk was positive, and the left was sluggish. There was no response to plantar stimulation on either side.

Laboratory Data: The blood count was within normal limits except for a slight leukocytosis. During the hospital course she had periods of leukocytosis with a marked shift to the left and gradually she developed an increasing hypochromic anemia. The urine had a low specific gravity, ranging between 1005 and 1010; the albumin varied between 15 mgm percent and 600 mgm percent and contained occasionally hyalin and granular casts, erythrocytes and frequently many leukocytes. The blood sugar was under good control throughout the hospital course, the nonprotein nitrogen was 37 mgm percent on admission, and the cholesterol was 380 mgm percent. The spinal fluid on two occasions was clear, colorless, and on February 21, 1951 had a total protein of 90 mgm percent, a colloidal gold curve of 1111110000, a cell count of 1. On February 28, 1951 the total protein was 30 mgm percent, the gold curve was 1112321000, and no cells were found. Twice the serum was: Kahn doubtful; Wassermann negative; VDRL positive. A lumbosacral spine plate on admission showed a calcified abdominal aorta and was suggestive of minimal arthritic changes. The electrocardiograms in 1946 and 1949 were consistent with myocardial pathology on the basis of coronary artery disease.

Course: The clinical impression was that of a lesion of the spinal cord between L2 and L5. Tumor, hemorrhage, infarct of the spinal cord and primary or metastatic tumor of the conus were considered. The paralysis, numbness, pain of the back and the disturbances of urination and defecation remained essentially unchanged throughout the hospital course. The patient received supportive measures, was fitted with leg braces for ambulatory care and was discharged. However, she returned to the hospital because of lack of nursing at home. Towards the end of the hospital course the patient became confused and was paranoid on several occasions. She also developed decubital ulcers followed by sepsis. She expired on November 10, 1951, about five months after the onset of her illness.

Permission for a postmortem examination of the trunk and spine was obtained. The essentials of the anatomic diagnosis are: marked emaciation; decubital ulcers of the trunk and extremities; subcutaneous abscess of the back; bilateral hypostatic bronchopneumonia and abscesses of the lungs; calcified atherosclerosis of the aorta and its main branches; marked nephrosclerosis of the kidneys; multiple fibrous scars of the myocardium; etc.

Changes of the spinal cord.—After fixation of the spinal cord in a solution of formaldehyde, transverse segments of the upper thoracic, the lower thoracic, the upper lumbar, and the lower lumbar regions were removed for histological examination. Sections from these levels were stained with hematoxylin and eosin, and by the Bielschowski's, Mallory's phosphotungstic acid-hematoxylin and Pal Weigert's methods. The leptomeninges at all levels had a slight fibrous thickening, the wall of the spinal arteries was thickened, especially the lining edge. The spinal cord in the thoracic levels was unchanged. However, the cord in the upper lumbar region was reduced in size, the gray and white matter being markedly decreased and in the sections the right anterior fiber tracts were vacuolated and had a proliferation of glia tissues. The lower lumbar region of the cord had the greatest changes. Here was an extensive necrosis of the anterior portion of the spinal cord with bilateral destruction of the ventral bundles and most of the anterior horn cells of the gray matter, more marked on the left side (Figures 1 and 2). This sharply defined, necrotic focus had a few remaining nerve fibers, bands of basic fibrous stroma, blood vessel tissues and numerous large pale mononuclear phagocytes. The left lateral and ventral spino-thalamic tracts had many vacuoles and some of the nerve trunks around the cord had regions of necrosis. The cells and the nerve tracts of the dorsal portions of the cord were not involved. The cause of the necrosis in the anterior portion of the cord was related with atherosclerotic changes in the intrinsic branches of the anterior spinal artery given off at this level. Two branches in the sections (Figure 3)



Figure 1. Photomicrograph illustrating the extensive infarct in the anterior portion of the lumbar region of the spinal cord.

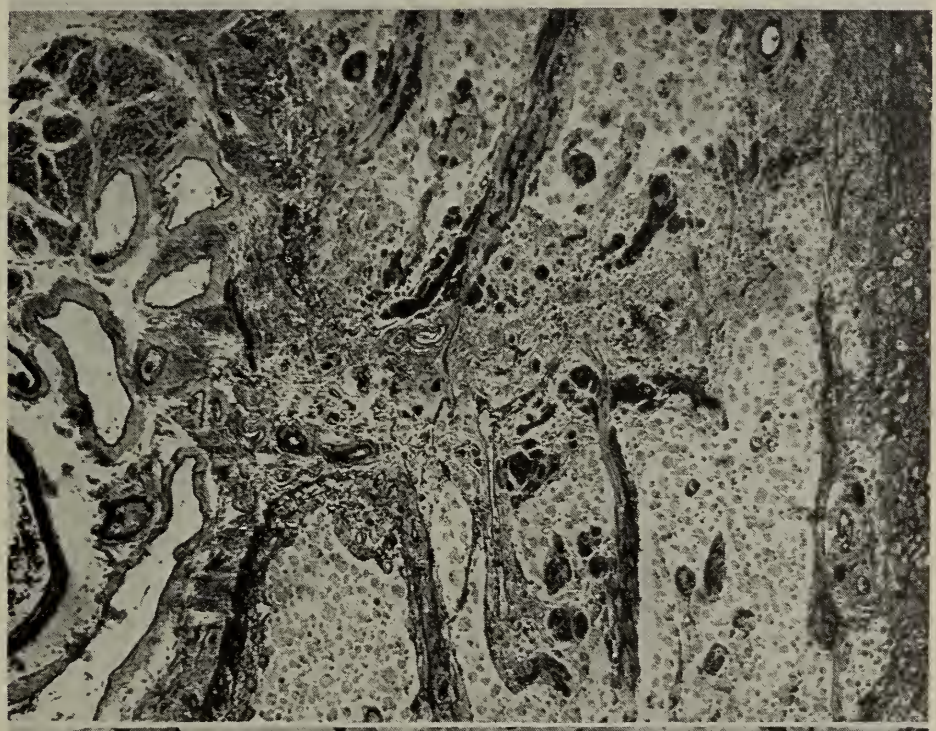


Figure 2. Photomicrograph illustrating details of tissue changes in the infarct of the cord. The anterior spinal artery is at the left margin, its penetrating branches with atherosclerotic occlusion are nearby, and smaller branches with narrow channels extend toward the necrotic tissues of the spinal cord. Only residues of supporting stroma with large mononuclear phagocytes remain of the cord tissues. . .



Figure 3. Photomicrograph illustrating at the lower left a portion of the anterior spinal artery. Above and below toward the right are the nutrient branches to the spinal cord with atherosclerotic occlusion. Note the wide mesh of fibrous tissues with large lipophages in the intima of these vessels.

extending toward the anterior median sulcus of the cord had a marked thickening of the intima by a mesh of fibrillar stroma in which were many large pale lipophages. The lumen of these vessels was reduced to a minute channel and the small arterial branches penetrating the cord also had a small lumen and hyalin fibrous thickened walls.

COMMENTS

An elderly woman with severe generalized atherosclerosis had an atherosclerotic occlusion of the sulco-commissural branches of the anterior spinal artery in the lower lumbar region with focal necrosis of the ventral portion of this segment of the spinal cord. The clinical symptoms were those described for anterior spinal artery occlusion at this level. The syndrome of anterior spinal artery occlusion as described in various published reports is a sudden paraplegia, dissociation of sensibility of the syringomyelic type and disturbances of urination and defecation. The anatomical lesion is an anemic necrosis of more or less extensive portions of the anterior two-thirds of the spinal cord supplied by the anterior spinal artery through its branches. The clinical symptoms vary somewhat with the level and the extent of the lesion. Most frequently, the occlusion occurs at the cervical and the thoraco-cervical level. The lumbar and particularly the low lumbar levels are rarely involved. The most common etiology of this disease entity is atherosclerosis of the vessels.

A short review of the blood supply of the anterior spinal cord, the internal structure of the spinal cord and the characteristics of anterior spinal artery occlusion at its different levels is presented.

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VASCULAR PAIN

The symptom of pain is one of the most constant features of peripheral vascular disease. Persistent pain usually is seen with ulceration and gangrene or with sudden arterial occlusion or arteritis. Intermittent pain which is dependent upon temperature changes occurs with Raynaud's syndrome (cold) or with erythermalgia (heat). Intermittent pain which is precipitated by exercise and relieved by rest is called intermittent claudication, and this may be a symptom of several of the organic vascular diseases. If the pain is brought on by posture it may indicate lymphedema or chronic venous insufficiently. Numbness, tingling, or burning are variants of the pain sensation. The patient may be timed with a stop watch and made to walk at a rate of 120 steps a minute and the time elapsing between the beginning of the test and the beginning of pain is known as the claudication time and this may be re-checked from time to time to denote progression or regression of the condition as well as in the evaluation of therapeutic agents. *Phil B. Bleeker, M.D., Classification and Diagnostic Tests in Peripheral Vascular Diseases. J. Tennessee M.A., Sept.* 1952.

NEWS OF THE STATE



CHAMPAIGN

Graduate Conference.—Physicians from nineteen surrounding counties were guests of the Champaign County Medical Society at the Elk's Club, the Hotel Tilden Hall, April 9.

The occasion was a postgraduate conference presented by the faculty of the Chicago Medical School, under the sponsorship of the Illinois State Medical Society.

At the same time the Woman's Auxiliary of the Champaign County Medical Society entertained wives of the physicians attending the meeting with a luncheon at 1:00 p. m. in the Lincoln Hotel, Urbana, followed by a tour of the Exhibit of Contemporary Art at the University of Illinois.

The postgraduate conference, which opened at noon with luncheon, is one of a series being staged by the Illinois State Medical Society throughout the state to bring top teachers and the latest developments in medicine to busy practitioners.

Arnold H. Leavitt, M.D., of Champaign, secretary of the Champaign County Society, was in charge of arrangements and Harlan English, M.D., of Danville, 8th district councilor of the state society, presided.

The after dinner speakers were Harold M. Camp, M.D., of Monmouth, secretary of the State Society, who spoke on "Organized Medicine" and F. J. Mullin, Ph.D., dean of Chicago Medical School, "The Internship." J. B. Christie, M.D., president of the Champaign County Society, toastmaster.

The afternoon speakers and their academic titles were: Donald S. Miller, M.D., Professor and Chairman, Department of Orthopedic and Traumatic Surgery; Steven O. Schwartz, M.D., Professor of Hematology; David M. Cohen, M.D., Professor and Acting Chairman, Department of Dermatology; Leonard A. Stine, M.D., Assistant Professor of Medicine; Harry H. Garner, M.D., Professor and Chairman, Department of Neurology and Psychiatry; Leo M. Zimmerman, M.D., Professor and Co-Chairman, Department of Surgery; Maxwell P. Borovsky, M.D., Professor and Chairman, Department of Pediatrics; Philip J. Stein, M.D., Associate in Gynecology; Maurice H. Cottle, M.D., Professor and Chairman, Department of Otolaryngology.

COOK

Branch Meetings.—A symposium on the acute abdomen was conducted by the North Shore Branch of the Chicago Medical Society at a meeting at the Edgewater Beach Hotel, April 7. Speakers were Dr. Edmund Foley on "Medical Diseases Simulating the Acute Abdomen"; Manuel E. Lichtenstein, "Variations in Signs and Symptoms of the Acute Abdomen in the Very Young and the Very Old", and Peter Rosi, "Diagnosing the Acute Abdomen".—The North Side Branch was addressed April 2 by Dr. Earl T. Engle, New York, on "Trends in Reproductive Physiology"; M. Edward Davis, "Estrogenic Therapy in Gynecology"; Roland R. Cross, Jr., "Male Sterility"; Richard J. Meyer, "Some Therapeutic Aspects of Adrenocorticotropin and Cortisone", and Dwight E. Clark, "Radioactive Iodine".

Personal.—Dr. Opal E. Hepler, Chicago, addressed the Toledo, Ohio, Academy of Medicine, recently on "Renal Functions: Their Practical Evaluation". Dr. Hepler is associate professor of pathology at Northwestern University Medical School and director of the clinical laboratories at Passavant Memorial Hospital.

Society News.—Dr. Louis B. Newman, Chief of the Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Hines, addressed

the personnel of the Chicago Board of Education associated with the Schools for the Physically Handicapped Children March 3. Dr. Newman's subject was "Total Rehabilitation in Neurological Disabilities".

New Cancer Research Hospital Opened.—An atomic-age development, the Argonne Cancer Research Hospital, was formally opened at the University of Chicago March 14, as the latest addition to the city's vast medical research resources.

First building especially designed and equipped to use all known radiation sources for the study of cancer, the hospital was built at a cost of $4,200,000 in funds of the Atomic Energy Commission.

It will be operated by the University as part of its cancer research center, under the direction of Dr. Leon O. Jacobson, professor of medicine. Dr. Robert J. Hasterlik, assistant professor of medicine, and director of health service, Argonne National Laboratory, is associate director. Facilities of the hospital will be available to the Argonne National Laboratory and the 32 universities and other research institutions of the mid-west which are participating members of the Laboratory.

The hospital is eight floors in height, with two of the floors below ground, where the earth will help shield radiation. Only two of the floors are for patient care and provide 56 beds. The rest of the building houses numerous radiation devices and laboratories.

Special measures have been taken to protect the patients on the two patient floors of the hospital, the third and fourth floors. Individual rooms are separated by eight inch concrete walls to prevent spread of contamination if any one room becomes radioactive. The floors are plastic covered for ease in removing any contamination.

Precautions also are taken on the third floor, where patients are treated with radioactive isotopes, including forms of iodine, phosphorus and gold, as well as chromium which is used in tracer studies.

Gowns, rubber gloves, and plastic overshoes, all washable, are worn by those entering rooms where radioactive contamination may be spread. Visitors are forbidden for a 48-hour period for those patients who have received isotopes, in order to prevent visitors from spreading radioactivity in the hospital.

These floors are checked every day by health physicists using Geiger counters. The linen from these patient rooms is also checked with a Geiger counter before it is sent to the laundry. Nurses and attendants wear special badges which register exposure to radiation.

There is a special shielded room on the third floor for surveying patients who have taken tracer doses of materials. This shielding is required, not for the protection of the patients or the staff, but to permit detection by delicate instruments of the relatively small amounts of radiation localized in the patients' bodies.

In the sub-basement are located twelve 12,000-gallon glass-lined storage tanks, where wastes from radioactive materials are accumulated until they are inactive or are disposed of through the special facilities of the A.E.C.

The second and fifth floors of the hospital are given over to fundamental research on cancer. On the fifth floor, carbon 14, tritium (radiohydrogen), and the gas radon, are being used in studying the chemical activities in patients with cancer and also in cancerous animals. These radioactive isotopes will be used to label and trace basic chemicals involved in either the growth or the destruction of tumor tissue.

Under the direction of Weldon G. Brown, professor of chemistry, a group of scientists are engaged in substituting these radioisotopes for non-radioactive atoms in the compounds that take part in these body activities.

Members of the departments of medicine and pharmacology, headed by Dr. George V. LeRoy, associate professor and associate dean of the division of biological sciences, are tracing these compounds in patients and animals. Also on this floor, a group under Dr. Hasterlik is investigating patients with radium poisoning and other forms of radiation injury.

All laboratories on this floor are equipped with special safety devices, including hoods for the handling of radioactive materials where there is danger of air contamination. Also located on this floor is the health physics group, which establishes safe procedures for handling radioactive material, supervises the laboratories for contamination, checks on the personnel, and supervises the disposal of wastes.

The animal laboratories on the sixth floor provide mice, rats, rabbits, and guinea pigs for the studies of the effect of radiation. Most widely used will be the strain of hybrid mice bred for a uniform response to the effects of radiation. A thousand of these mice will be produced every week. In these animal experiments, two 250,000-volt X-ray machines provide the radiation, and smaller X-ray machines are used in animal diagnosis.

On the second floor are the laboratories of Dr. Jacobson and Dr. Dwight E. Clark, professor of surgery. Studies by Dr. Jacobson or irradiation effects on mice have indicated the existence of certain blood forming factors in the body. He will continue this investigation and also studies of leukemia and other forms of blood cancers. In this research, he and his group are using radiophosphorus and radioiron as tracers in the study of blood formation and blood diseases. Radiochromium will be used to study the length of life of red blood cells.

Dr. Clark, who is the largest single "consumer" of radioiodine in the United States, will continue his studies of thyroid functioning and disease.

The radioisotopes themselves will be stored in two-foot-long lead containers which fit inside these stainless steel tubes. The lead around each shipment of isotopes is sufficient to prevent radiation from escaping. The concrete will prevent the irradiation

from many containers from building up to potentially dangerous levels.

The sub-basement of the hospital is 19 feet below street level, and 12 feet below the permanent water table. Thus special methods of construction were required to keep the sub-basement dry. In it, in addition to the waste storage tanks, are heavily shielded rooms for the irradiation of both patients and animals.

These operations can be watched by the investigators through windows up to three feet in thickness, containing solutions of zinc bromide. The windows not only stop radiations, but even permit the scientists to "see around corners" because of the way they bend light rays. Developed at Argonne National Laboratory, five of these windows cost $10,000.

The two-million-volt Van de Graaff generator, which will produce a high energy beam of either X-rays or electrons, is already installed. It will be used to study the usefulness of the "super-voltage" attack on cancer and also to study conventional methods of rotational therapy. In this, the patient is rotated while in the beam of radiation, so that a maximum amount of energy falls on the tumor, and a minimum amount on surrounding tissues which are less continuously exposed during the rotation.

Yet to be installed is a cobalt-60 "bomb" which will be attached to an apparatus permitting the source of X-rays rather than the patient to be rotated. This device, expected to be in operation this coming summer, will also be unique because the cobalt 60 source will be shielded by uranium rather than the conventional lead shielding. This permits a weight reduction of from 4,000 down to 950 pounds.

Within a year, the third major device will be installed in the form of a linear accelerator. This machine steps up the energies of an electron beam to fifty-million volts, to a point where they have sufficient energy to pass through the human body. This beam will be used in the direct treatment of cancer.

In addition to these devices, arrangements are being made to use the 450-million-volt synchrocyclotron in the University's Institute for Nuclear Studies. Protons from this second most powerful of the operating atom-smashers will be used in the direct attack on cancer. Taken together, all these devices will give scientists access to all types of radiation which are now known and are thought to be useful in the treatment of cancer.

COOK

Grants for Research.—Seven research grants have been awarded recently to the University of Illinois College of Medicine by private industry, pharmaceutical houses, and national and local health organizations and individuals. The donors are as follows:

Lederle Laboratories Division of the American Cynamid Company, Pearl River, N. Y., $10,000, in support of work of an investigative nature in infectious diseases and related fields. The study is under the direction of Dr. Harry F. Dowling of the Department of Medicine.

The Teagle Foundation, Inc., $8,000, for the renewal of a grant in support of research in paralysis agitans. Dr. Ralph W. Gerard of the Department of Psychiatry is directing the project.

Smith, Kline and French Laboratories, Philadelphia, Pa., $5,000, to provide a fellowship for the current academic year. This grant is under the direction of Dr. C. C. Pfeiffer of the Department of Pharmacology.

Parke Davis and Company, Detroit Mich., $3,600, for a study entitled "Blood Dyscrasias." The grant is being supervised by Dr. Stephen B. Binkley of the Department of Biological Chemistry.

National Tuberculosis Association, $3,351.66, for the study of mucoproteins of human plasma, which is under the direction of Dr. Richard J. Winzler of the Department of Biological Chemistry.

Ortho Research Foundation, Raritan, N. J., $1,500, to provide for a research project entitled "A Comparison of Calcium Ferrous Citrate,, Moliron and Ferrous Sulfate in the Treatment of Secondary Anemias of Pregnancy." Dr. Frederick H. Falls of the Department of Obstetrics and Gynecology directs this project.

Lakeland Foundation, Chicago, $1,320, for the study involving an attempt to isolate the growth stimulating and inhibiting agents from the liver or intestinal mucosa.

Postgraduate Course in Hematologic Diagnosis.—A course in hematologic diagnosis for graduate physicians will be given at the Michael Reese Hospital by Dr. Karl Singer, Director, Department of Hematologic Research, Medical Research Institute, July 20-August 1, 1953. The course gives a review of the present trends in hematology as well as instruction in actual reading of slides, normal and pathologic, peripheral blood and bone marrow. An individual slide collection is provided and may be retained by the participants. A demonstration of all immuno-hematologic as well as of the modern tests for disturbances of the clotting mechanisms is scheduled. Further information and a copy of the curriculum may be obtained from the Department of Hematologic Research, Medical Research Institute, Michael Reese Hospital, Chicago, Illinois.

Northwestern Alumni Dinner.—The Northwestern University Medical Annual Faculty-Alumni Reunion dinner will be held Saturday evening, May 23, Hotel Knickerbocker, 163 E. Walton Street, Chicago. Social period at 5:30 p.m. and dinner at 7:00 p.m. Dinner tickets $9.00 a plate; wives also invited to attend. Entertainment by Medical students en-

titled "Quo Vadis Medicus?-'53". Make reservations at Medical Alumni Office, 303 E. Chicago Avenue, Chicago 11, before May 20.

Progress in Endocrinology.—The Chicago Medical School opened a series of lectures on "The Progress in Endocrinology" April 7. The series as it appeared in the official program is as follows: Drs. Sidney P. Colowick, Baltimore, Rachmiel Levine, and DeWitt Stetten, Jr., New York, April 7, "The Mechanism of Insulin Action, a Round Table Discussion"; I. Snapper, April 14, "Parathyroid Hormone and Calcium Metabolism"; Piero P. Foa, April 21, "Glucagon: the Hyperglycemic Hormone of the Pancreas"; I. J. Pincus, Philadelphia, May 5, "The Liver in Endocrine Disturbances; Dwight E. Clark, May 12, "The Use of Radioiodine in Thyroid Disease; Thomas L. Dao, May 19, "Adrenal Glands and Cancer of the Breast"; Edward F. Rosenberg, May 26, "Adrenal Cortical Steroids in the Treatment of Rheumatic Diseases", and Morton J. Grossman, June 2, "Hormones of the Gastrointestinal Tract".

Heart Session.—A meeting of the Clinical Section of the Chicago Heart Associattion was held on Tuesday evening, March 17, at the Chicago Academy of Sciences. The following program was arranged by the Medical Service of Hines Hospital, Dr. Lyle A. Baker, Chief:

1. Blood Volume in Cardiac Failure — Dr. Ervin Kaplan; Discussant — Dr. George V. LeRoy; 2. Myocardial Infarction following Non-penetrating Chest Trauma — Dr. William Andrews; Discussant — Dr. Chauncey C. Maher; 3. Clinical Evaluation of Mitral Commissurotomy — Dr. William O'Connor; Discussant — Dr. Richard Langendorf; 4. Involvement of the Heart and Pericardium in Hodgkin's Disease — Dr. Lyle A. Baker; Discussant — Dr. Otto Saphir.

Dr. Walter S. Priest is Chairman of the Clinical Section of the Chicago Heart Association and Dr. Clayton J. Lundy is Program Chairman. All physicians were invited to attend the March 17 meeting, which was part of the Heart Association's broad program of professional education.

Appointments at Illinois.—Appointment of Drs. Gabriel Langfeldt and Isadore Snapper as lecturers in the University of Illinois College of Medicine, with the rank of professor, has been approved by the Board of Trustees.

The Board also has confirmed the appointment of Dr. David S. Ruhe as clinical assistant professor of medicine.

Dr. Langfeldt will serve the University as a lecturer in psychiatry. At the present time, Prof. Langfeldt is engaged in advanced psychiatric research at the Manteno State Hospital on a Fulbright Fellowship. He is professor and chairman of the Department of Psychiatry at the University of Oslo.

Dr. Snapper will serve as a lecturer in the Department of Medicine. At the present time, he is educational director of Cook County Hospital. Prior to accepting that position on Jan. 1, he was director of medical education at Mt. Sinai Hospital, New York City, and clinical professor of medicine at New York University.

Dr. Ruhe presently holds a full-time position as director of the Medical Audio-Visual Institute of the Association of American Medical Colleges. He previously held teaching appointments at Emory University School of Medicine and New York Medical College. He holds bachelor of science and master of science degrees from Michigan State College, and the doctor of medicine degree from Temple University.

Associate Director Named for Cleft Palate Clinic.—Dr. Walter W. Dalitsch has been named associate director of the Northwestern University Cleft Lip and Palate Institute. Dean Charles W. Freeman of the dental school said Dr. Dalitsch will begin his new duties Sept. 1.

Dr. Dalitsch is a staff member of the institute and associate professor of oral surgery at the dental school.

The institute is maintaining a complete rehabilitation program for the cleft palate child, as well as furthering research and education in this field.

Oppenheim Lecture.—Dr. Sidney Farber, Director of Research of the Children's Cancer Research Foundation, Boston, delivered the fourth annual Maurice Oppenheim Lecture at the Chicago Medical School, April 10, on "The Nature and Treatment of Certain Lipid Metabolic and Related Disorders." The lectureship was established at the Chicago Medical School by Alpha Rho Chapter of Phi Lambda Kappa.

London Physician Lectures at University of Chicago.—Dr. Austin Bradford Hill, professor and director of the department of medical statistics and epidemiology, London School of Hygiene and Tropical Medicine, University of London, delivered a lecture at the University of Chicago School of Medicine April 29. His topic was "The Philosophy of the Clinical Trial." Dr. Hill made a tour of the University the following day.

LAKE

Personal.—Dr. Charles U. Culmer was recently voted to membership in the Lake County Medical Society. Dr. Culmer, a native of Duluth, Minnesota, received his premedical, medical and postgraduate education at Northwestern University. He is a veteran of World War II and is a diplomate of the American Board of Surgery.

Society News.—A joint meeting of the Lake County Medical Society and the Medical Officers of the Great Lakes Naval Station and Downey Veterans Administration Hospitals was held at the Elks Club, Waukegan ,March 10. This was a fellowship meeting.

MACON

Personal.—Dr. David Wilbur, who for the last three and one half years has been the only physician in Niantic, has been recalled to service and will report to Brooke General Hospital, Fort Sam Houston, San Antonio, Texas. His rank is to be first lieutenant, according to the Macon County Medical Society Bulletin.

Society News.—"Differential Diagnosis of Jaundice" was discussed by Dr. Edmund F. Foley, clinical professor of medicine, University of Illinois College of Medicine, Chicago, before the Macon County Medical Society at the St. Nicholas Hotel, March 26.

MADISON

Society News.—At the March meeting of the Madison County Medical Society, Dr. C. Reed Boles, St. Louis, spoke on "Problems of the New Born."

MERCER

Physician Honored.—Dr. Charles M. Murrell, Sherrard, was recently honored with a public party for his forty years of service as a physician of Mercer County. Dr. Murrell moved to Moline after living in Sherrard since 1925, according to the Bulletin of the Iowa-Illinois Central District Medical Association.

ROCK ISLAND

Society News.—Dr. W. D. Snively, Jr., Medical Director, Mead Johnson and Company, Evansville, Indiana, addressed the Rock Island County Medical Society March 10 on "The Syndrome of Hypoproteinosis of Childhood." Dr. Walter C. Alvarez, formerly head of the department of medicine, Mayo Clinic, Rochester, addressed the May meeting of the Iowa-Illinois District Medical Association on "How Do Women Get So Nervous." The dinner meeting was held at the Plantation in Moline.

Staff Election.—Dr. E. F. Parker, Moline, was recently elected president of the staff of Moline Lutheran Hospital, suceeding Dr. Paul Linden. Other new officers are Dr. J. G. Gustafson, vice president and Dr. Philip V. Hall, secretary. Dr. L. C. Arp, George Koivun and Paul Youngberg were elcted to the executive committee.

SANGAMON

Dr. Baer Resigns.—Dr. Walter N. Baer recently resigned as deputy director of the state mental health department of public welfare, newspapers reported.

WINNEBAGO

Graduate Conference.—The Winnebago County Medical Society was host March 11 to physicians from a dozen surrounding counties in Illinois, Iowa and Wisconsin.

The occasion was a postgraduate conference beginning at 1:00 p.m. and extending into the evening at which five speakers from the University of Chicago School of Medicine discussed new developments in medicine. The conference was arranged by the Illinois State Medical Society, whose secretary, Dr. Harold M. Camp of Monmouth, also spoke.

The meeting was held in the Faust Hotel. Dr. Joseph B. Kirsner, Dr. Theodore N. Pullman, Dr. Roger C. Baker, Jr., and Dr. Charles P. McCartney will each give two papers on various subjects. The dinner speakers were Dr. Camp and Dr. Lowell T. Coggeshall, dean of the University of Chicago division of biological sciences.

Wives of those attending were entertained by the Winnebago Woman's Auxiliary.

GENERAL

"How's Your Health" over WGN-TV.—"How's Your Health", produced by the **Educational Committee** of the **Illinois State Medical Society** in association with WGN-TV, has presented the following telecasts:

George Wakerlin, professor and head of the department of physiology, University of Illinois College of Medicine, March 23, on "Living With Your Blood Pressure".

James Segraves, clinical assistant in bone and joint surgery, Stritch School of Medicine of Loyola University, March 30, on "Casts for Fractures".

Hans Von Leden, assistant professor of otolaryngology, Northwestern University Medical School, April 6, "You Breathe to Live". Equipment was provided by Clay-Adams Company and Denoyer-Geppert Company.

Arthur J. Atkinson, assistant professor of medicine, Northwestern University Medical School, April 13, "The Physiology of Digestion". Equipment was provided by Standard X-Ray Company and Denoyer-Geppert Company.

Theodore R. Van Dellen, assistant dean at Northwestern University Medical School, and Medical Editor of the Chicago Tribune, appeared in all telecasts as moderator.

"Your Doctor Speaks" over **FM Station WFJL.**—In the radio series "Your Doctor Speaks" over FM Station WFJL, the following physicians appeared in transcribed broadcasts under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Morton A. Goldmann, associate attending physician, department of internal medicine, Cook County Hospital, March 26, "How Can You Avoid Trouble With Your Heart".

Herbert D. Trace, adjunct in surgery, Mt. Sinai Hospital, April 2, "Heart Surgery".

Allen C. Hrejsa, associate attending surgeon, Illinois Masonic Hospital, April 9, "Your Ulcer—Does It Deserve Surgery".

Paul C. Tracy, member of the pediatric staff, Children's Memorial Hospital, April 16, "Infant Feeding".

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

George L. Drennan, Jacksonville, Bond County Health Improvement Association in Greenville, March 30, on "Medicine: 1953".

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Harry A. Oberhelman, Chicago, Lee-Whiteside County Medical Society in Dixon, April 16, on "Massive Upper Gastrointestinal Tract Hemorrhages".

Stephen O. Schwartz, Chicago, DeKalb County Medical Society in Sycamore, April 28, on "The Value of Marrow Biopsy in the Evaluation of Anemias".

Donald I. Bell, Evanston, Bureau County Medical Society in Spring Valley, May 12, on "Types of Diabetes and Management".

Cleveland J. White, Chicago, Henry County Medical Society in Geneseo, May 13, on "Diagnosis and Treatment of Common Diseases of the Skin".

Frederick H. Falls, Chicago, Lee-Whiteside County Medical Society, Rock Falls, May 13, on "Classical versus Low Cervical Cesarean Section".

Chauncey C. Maher, Chicago, Stock Yards Branch of the Chicago Medical Society, May 14, on "Diagnosis of the Second and Third Coronary Thrombosis".

John L. Reichert, Chicago, Lee-Whiteside County Medical Societies in Dixon, June 18, on "Immunization Procedures With A Reference to Gamma Globulin".

Samuel L. Governale, Chicago, Henry County Medical Society, Geneseo, July 8, on "Newer Developments in the Treatment of Hernias".

American Geriatrics Society.—The tenth Annual Meeting of the American Geriatrics Society will be held at the Hotel Commodore, New York City on May 28-30. The first two days are devoted to scientific papers and discussions. The annual dinner will be held on Friday evening, May 29th. On Saturday afternoon the Society is invited to see the work being done at the William I. Sirovich Day Center, 203 Second Avenue, New York City, Miss Frances King, Director. Dr. Willard O. Thompson, Chicago, is president of the organization; Dr. Malford W. Thewlis, Wakefield, R. I., secretary; Dr. Richard J. Kraemer, Greenwood, R. I., treasurer.

SURGERY OF ADRENALS

Adrenal surgery is now in a fast moving evolutionary stage. The reasons for this recent interest in adrenal surgery are fourfold: 1, the discovery of cortisone which, together with previously available substances, makes it possible to maintain life in the absence of the adrenal glands; 2, the development of powerful adrenolytic agents (diabenamine, benzodioxane, and regitine) capable of blocking the action of epinephrine and norepinephrine, which are produced in excessive amounts by the adrenal medullary tumor, pheochromo-cytoma; 3, the isolation and availability of norepinephrine, a powerful vasopressor agent; and 4, improved surgical technique. *Harold A. Zintel, M.D., Recent Advances in Surgery of the Adrenal Gland. Pennsylvania M. J., Sept.* 1952.

THYROID CARCINOMA

Carcinoma originating in an adenoma of the thyroid usually is papillary and may grow slowly and metastasize to the nodes of the neck very gradually. On the other hand, primary carcinoma arising in the thyroid gland itself, rather than in an adenoma, usually is of the aveolar type and spreads more rapidly by the blood stream to the lungs. When the so-called lateral aberrant thyroid carcinoma is present, the condition would be treated as what it really is. It is carcinoma arising in the lobe of the thyroid with metastasis to the adjacent cervical nodes. This condition is treated best by the total removal of the isthmus and corresponding lobe of the thyroid, together with an incontinuity radical neck dissection on the involved side. *James M. Ovens, M.D., The Therapy of Carcinoma of the Thyroid Gland. Arizona Med. Nov.* 1952.



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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



MEDICAL MANAGEMENT OF PERIPHERAL VASCULAR DISEASE

Addison B. Scoville, Jr., M.D., and Morse Kochtitzky, M.D. In THE JOURNAL OF THE TENNESSEE STATE MEDICAL ASSOCIATION, 45:9:339, September 1952.

One of the greatest challenges in the field of internal medicine is the proper management of diseases involving the peripheral circulation. Peripheral vascular disease implies an imbalance between the metabolic needs of the tissue and its blood supply. Physical medicine offers several methods designed to correct this imbalance.

Heat may be used either directly or indirectly. The direct application of heat by any means including thermo-regulated foot cradles is potentially dangerous. If the increase in blood supply by vasodilatation is not greater than the increase in metabolic activity brought about by heat, tissue death is inevitable. The most frequent cause of gangrene is the injudicious use of heat. On the other hand, reflex heat or maintaining the environmental temperature at 80-85 degrees F. is worthy of use. Advising a patient to place his hands and arms in hot water to warm his feet is sound advice. Here reflex vasodilatation is achieved without increasing metabolic activity.

The mechanical alteration of blood flow by exercise beds, venous compression, and massage is another method used in physical medicine. Probably the chief value of Buerger's exercises is to encourage the patient to care for his feet. Exercise such as walking up to tolerance is effective in increasing blood supply to the muscles. Passive vascular exercises and intermittent venous compression are not used often at the present time. The oscillating bed used intermittently or continuously is a most satisfactory form of mechanical therapy.

A METHOD OF QUANTITATIVE HEAT APPLICATION TO SMALL SKIN AREAS AT CONTROLLED TEMPERATURE

V. Guillemin, F. Benjamin, T. Cornbleet and M. I. Grossman. In JOURNAL OF APPLIED PHYSIOLOGY, 4:12:920, June 1952.

In connection with certain experiments on the effects of heat stimulation on small areas of the human skin, it became necessary to design a probe for applying measurable quantities of heat energy at known temperatures. The instrument described here has been found to be well adapted for this purpose and incorporates certain novel features of construction which merit description.

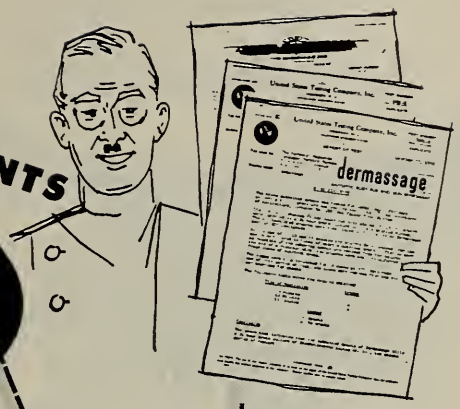
The important specifications to be met are: (1) The temperature of the probe should be constant over the whole surface of contact. (2) The temperature sensing element should indicate the true temperature of the probe surface. (3) The heat capacity of the heater-thermometer assembly should be as low as possible. (4) The

(*Continued on page* 46)

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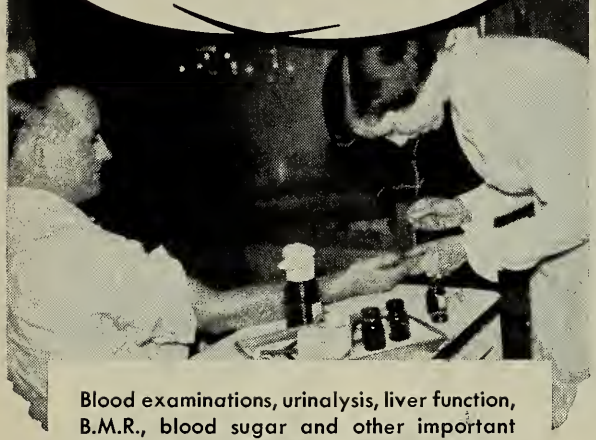
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Physical Medicine (Continued)

temperature is indicated directly on a dial (rather than being found, for example, by balancing a potentiometer) which adds greatly to the convenience of use of the probe. It is also desirable that the instrument be rugged, stable, portable and convenient to operate.

Methods are described for calibrating the probe and for determining how closely the indicated temperature corresponds to the true temperature of the probe tip surface. This probe has been used to determine the influence of temperature and duration of heat stimulation in the production of skin flare, macule and blister formation in the human skin.

PAIN REACTION TO LOCALLY APPLIED HEAT

F. B. Benjamin. In JOURNAL OF APPLIED PHYSIOLOGY, 4:12:907, June 1952.

An instrument has recently been designed and built by Guillemin of the Aeromedical and Physical Environment Unit of the University of Illinois which permits the heating of a small area (16 mm.) of the skin with immediate registration and accurate control of temperature and energy input. The heat is applied by means of a probe which ends in a thin square sheet of metal (0.5 x 4 x 4 mm.) which is in contact with the resistance thermometer and a heating element. A complete description of the instrument has been published earlier.

To determine the pain threshold with this instrument the applicator was placed on the skin and the probe temperature and indirectly the temperature of the skin with which it is in contact were increased with a constant energy input. The threshold was taken as the point where pain was first reported.

Ten normal young males, who were specifically trained for accurate perception of the pain threshold, were used. By changing the rate of temperature increase in a random fashion the element of subjectivity was largely eliminated.

The results show that the surface temperature at the time the pain threshold is reached is directly related to the heat energy input, and that the temperature gradient across the skin (measured with thermocouples) at the time the

(*Continued on page* 48)



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CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	.0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	.0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete) 32 Gm.
*CARBOHYDRATE 65 Gm.
*LIPIDS 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council

Physical Medicine (Continued)

pain threshold is reached is directly related to the heat energy input.

The findings are discussed in view of the various theories of heat pain and found compatible with the view of Buettner that heat pain is determined by a definite temperature level at a point slightly below the skin surface.

USE OF ULTRA-VIOLET LIGHT IN SKIN DISEASES

Clara M. Warren, M.R.C.S., L.R.C.P. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:9:205, September 1952.

In a recent review of famous textbooks on dermatology and x-ray therapy, Warren found that some writers were doubtful as to the value of ultraviolet light in dermatological conditions. It seemed that if ultraviolet light apparatus and administrators were available ultraviolet light was used, but if superficial x-rays were more accessible these were used more frequently.

This brings up the problem as to whether the ultraviolet light apparatus should belong to the skin department, there to be administered by qualified dermatologists, or whether the apparatus should remain as part of the department of physical medicine. In the latter case all skin patients would be seen by the physician in charge of that department, and that physician would not necessarily have had any dermatological experience, plus the fact that this would add to the number of patients waiting for physical therapy treatment.

As a dermatologist, Warren feels that she should order and supervise the administration of ultraviolet light herself so that there would also be more freedom in using local medicaments between treatments. She would be able to start treatment for the patient immediately without his having to be put on a waiting list for treatment. However, Warren also realizes that when the department of physical medicine supervises the treatment there is the benefit of discussions with the other physicians. New and different methods of treatment can be assessed, and the friendly cooperation helps to prevent further isolation of departments.

Warren gives a brief discussion of the various types of ultraviolet light, contra-indications and

(*Continued on page* 50)

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30 days of Nurse at Home	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital	5.00	10.00	15.00	20.00
Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
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Child over age 19	2.50	5.00	7.50	10.00

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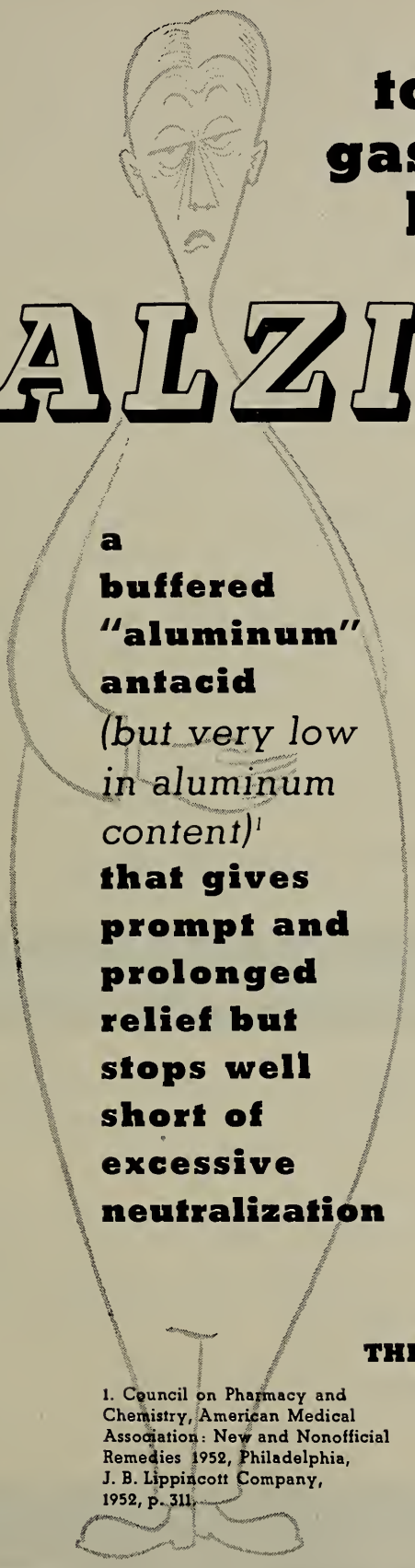
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1. Council on Pharmacy and Chemistry, American Medical Association: New and Nonofficial Remedies 1952, Philadelphia, J. B. Lippincott Company, 1952, p. 311.

dosage. The following skin disorders have been benefited by her treatment with ultraviolet light: pyodermas, infected fissures, moniliasis of mouth, acne, deep pustular acne, keloids, alopecia areata, psoriasis, vitiligo, synovial joint cysts, lupus vulgaris, and traumatic leg ulcers and varicose ulcers.

GAIT ANALYSIS OF THE HEMIPLEGIC PATIENT: FORCE PLATE AND STROBOSCOPIC STUDIES

Morton Marks, M.D. In PAN AMERICAN MEDICAL WOMAN'S JOURNAL, 59:4:17, April 1952.

The patient with hemiplegia is an extremely common problem, occurring in all age groups. Considerable interest has recently been directed toward the primary treatment of and the rehabilitative measures applicable for a reduction in the severity of the handicaps of these individuals. As gait abnormalities are obvious, emphasis has been placed upon their correction; but quantitative analyses which might afford a more objective evaluation have not been extensively carried out. It has long been felt that objective studies might be of value in determining the basic motor patterns responsible for the gait disturbance. In this way, the effect of gait training and the influence of the short leg brace, commonly prescribed to afford greater stability to the patient and counteract the talipes equinovarus position of the foot, could also be more objectively evaluated.

The force plate is an instrument recently developed to analyze gait patterns. It has developed into a complex apparatus which can measure the ground reactions used during walking, i.e., the forces developed during the period of contact of the lower extremity with the ground during the stance phase. Simultaneouesly, using an interrupted light camera similar to that developed by Marey, a stroboscopic photograph of the test subject can be obtained for the period during which the ground reactions are recorded. This photograph records the relative positions of the various segments of lower extremity to each other and in space throughout the walking

(*Continued on page* 52)

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Physical Medicine (Continued)

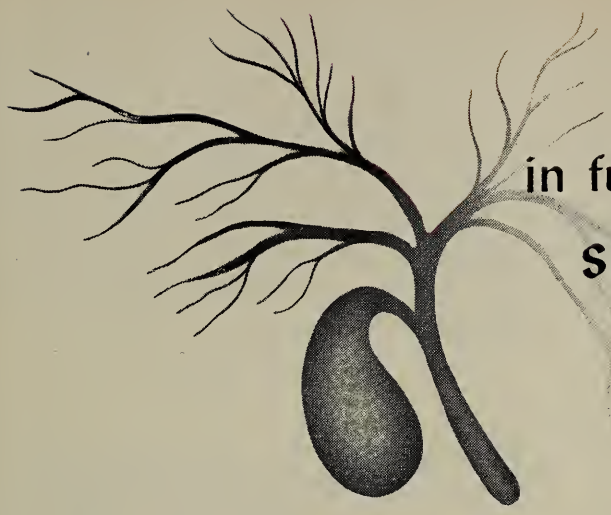
cycle. The joint movements, i.e., the angular forces developed at the joints, can be calculated from correlating the ground reactions with the exact position of the limb at that time. These methods have been extensively employed in the study of amputees, directed primarily at the design and perfection of artificial lower limbs that will duplicate the gait characteristics of the normal.

The gait characteristics of eleven moderately spastic hemiplegics have been studied. In all the cases the disturbance was ascribed to antecedent vascular accidents in the distribution of the middle cerebral artery, 6 weeks to 3 years prior to the study. The results of the right hemiplegic were compared with those of the left hemiplegic. Control records were obtained from normal subjects.

An analysis of the records disclosed abnormalities of motor performances of a similar character in the nonparetic as well as the paretic lower extremity. This corroborates well with other clinical and physiologic observations showing bilateral impairment of motor function in the presence of unilateral brain disease. Another interesting feature noted in this study was that neither the wearing of the short leg brace nor the period of retraining altered significantly the observed motor patterns. From this it must not be assumed that these procedures are valueless in improving the gait of the hemiplegic patient. Unfortunately, the nature of this study was such that only the stance phase could be adequately investigated. Since the maximal benefit of the brace seems to occur immediately prior to the stance phase, in that the abnormal position of the foot is corrected, insuring the patient of a stable support on which he can bear weight, final objective evaluation must await a more detailed and comprehensive gait analysis in which both phases can be considered.

The results of this study suggest also that some of the methods in use in attempting gait retraining are unphysiologic. It is commonplace for the therapist to teach the paient to lift his leg in initiating the swing phase. This results, if successful, in an exaggerated steppage

(*Continued on page* 54)



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Physical Medicine (Continued)

gait. A more normal physiologic pattern requires a "push off" effect, correlated with the forceful contraction of the gastrocnemius muscle. In addition, in view of the bilaterality of motor abnormality, it seems logical that training should stress the reciprocal bilateral nature of gait, with the nonparetic extremity receiving more attention than was commonly affored it in the past.

CIRCULATORY DISEASES OF THE EXTREMITIES

A. Wilbur Duryee, M.D. In NEW YORK STATE JOURNAL OF MEDICINE, 52:18:1275, September 15, 1952.

Since arteriosclerosis of the vessels of the extremities, varicose veins, and phlebitis make up an ever-increasing part of the general practitioner's problems, the author attempts in this article to evaluate certain modalities as they apply to various peripheral vascular diseases. He discusses the place of vasodilator drugs, antibiotics, anticoagulants, mechanical agents, and surgery in peripheral vascular diseases.

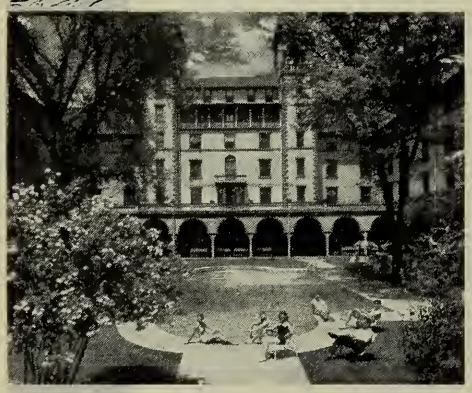
Duryee concludes that there are no specific therapies in peripheral vascular disease. No outline of treatment can be given which would fit even the majority of patients suffering from any one of the usual peripheral vascular diseases. He cautions that enthusiasm for any one modality of treatment should not tempt the physician to depend upon it alone, for much of the improvement is spontaneous, and credit should not be given to a particular therapy without just reason.

Tuberculosis continues to exert a greater influence upon the health and welfare of mankind than does perhaps any other infectious disease. It is a disease which frequently occurs during the early adult years of life and significantly during the economically productive years. Tuberculosis affects not only the patient as an individual but also influences the patient's entire family. The future activities and the social progress of the patient and his family are frequently altered, sometimes for better and sometimes for worse. As a truly clinical disease, tuberculosis continues to be one of the most frequently missed diagnoses. James M. Blake, M.D., N.Y.S. J. of Med., Feb. 1, 1952.



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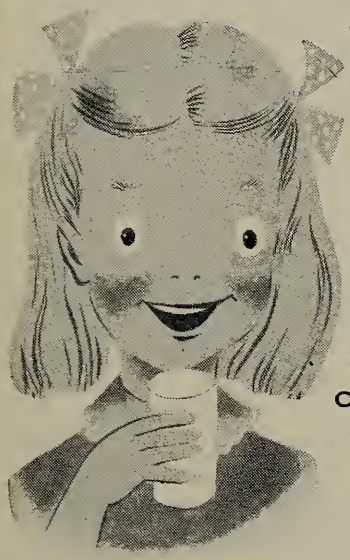


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BOOK REVIEWS



ENDOCRINE TREATMENT IN GENERAL PRACTICE.—Edited by Max A. Goldzieher, M.D., Joseph W. Goldzieher, M.D. Published by Springer Publishing Company, Inc., New York. Date of Publication: Jan. 23, 1953. Price $8.00.

In contrast to the usual textbook on endocrinology this text has been completed with emphasis upon practical treatment. All extraneous material dealing with experiment work, conflicting theories and detailed complicated chemical and physiological reactions have been eliminated.

Twenty-one specialists in the various fields of medicine and surgery have collaborated in presenting a simple, direct guidebook on endocrine therapy which applies to the general practice of medicine. For this reason the book is arranged according to the types of metabolic disturbances and the localization of the presenting symptoms. This is in sharp contrast to the time-honored method used in most endocrine texts in which the individual glands and their pathology are discussed separately.

The latest uses of cortisone and A.C.T.H. in a wide variety of clinical conditions is discussed with ample emphasis on what clinical response to be expected and what side effects to guard against.

J. W. P.

THE LITERATURE ON STREPTOMYCIN. By Selman A. Waksman. Revised Edition, 1952. Published by Rutgers University Press, New Brunswick, New Jersey. Price $5.00.

Since the isolation of streptomycin from the culture medium of an actinomyces belonging to the species streptomyces griseus in January 1944, over 6,000 papers have been published on the subject.

This 450 page book, presents a complete inventory of all the papers, articles, and abstracts concerning the subject. There is an increase of almost 4,000 references since the first edition was published in 1948.

J. W. P.

ELEMENTARY MEDICAL STATISTICS, THE PRINCIPLES OF QUANTITATIVE MEDICINE: by Donald Mainland, M.B., Ch.B., D.Sc., F.R.S.E., F.R.S.C., Professor of Medical Statistics, Division of Medical Statistics, the Department of Preventive Medicine, New York University College of Medicine. 327 pages with fig. 23. Philadelpheia and London: W. B. SAUNDERS COMPANY, 1952. Price $5.00.

"It is the physician's duty to do his best for his patients, and if he believes that there is some evidence in favor of a certain treatment he will feel bound to use it."

This book is designed primarily for practitioners or students who are to become practitioners, to help them develop an ability to evaluate what they read in medical journals and hear at medical meetings.

The author has organized his material well, and leads the reader step by step to an understanding of the application of statistics in the field of diagnosis.

J. C. S.

BACTERIAL AND MYCOTIC INFECTIONS OF MAN, Second Edition, edited by Rene J. Dubos, Ph.D., The Rockefeller Institute for Medical Research, with 36 collaborators. 1952. 900 pages. 98 illustrations. $7.50. J. B. LIPPINCOTT COMPANY, Philadelphia.

The second edition of this outstanding book is written

(*Continued on page* 60)

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BOOK REVIEWS (Continued)

by a distinguished group of contributors, who with a few exceptions, are from Eastern medical schools. There are sections on the role of bacteria in disease in general, the host-parasite relationship, serology and immunochemistry, allergy and blood groups as well as conventional chapters on individual bacterial diseases. The section on medical mycology is brief but fairly complete. The book concludes with chapters on sterilization, chemotherapy, epidemiology and applied medical bacteriology. The new material includes sections on bacterial genetics and physiology by Dr. Jacques Monod, blood groups by Dr. Philip Levine and chemotherapy by Dr. Walsh McDermott.

The writing is somewhat uneven, as is often the case in collaborative efforts. Evidently the day of textbooks written from and colored by the experience of one individual is passing, with the result that the information made available to us is more encyclopaedic although more difficult to absorb. This particular cooperative effort is much better reading than most.

J. C. S.

Atlas of Medical Mycology. By Emma Sadler Moss, B.S., B.M., M.D. and Albert Louis McQuown, B.S., B.M., M.D. Published by The Williams & Wilkins Company, Baltimore. 1953. Price $8.00.

This book is a must for all dermatologists and pathologists. It is a valuable asset in the library of any physician in general practice.

Most physicians are confused and a bit befuddled by the complexities of fungus diseases and rarely make a specific diagnosis. This textbook reduces the subject to a logical and understandable basis.

The first chapter is devoted to a classification of fungi. Subsequent chapters deal with the specific organisms. In these chapters, each large group of fungi are clearly elucidated as to etiology, classification and distribution. The clinical disease is described with both its cutaneous and systematic manifestations. Methods of x-ray and laboratory diagnoses are defined as well as its vital mycolgy.

These chapters are each concluded by a brief discussion of the histologic findings and practical methods of treatment and prognoses.

These separate chapters are well illustrated in clinical photographs of the organisms and histologic slide material taken from representative diseased tissue.

The final chapters deal with such titles as Immunology, Culture Media and Formulary.

J. W. P.

Forensic Medicine, Second Edition, by Keith Simpson, M.D. (Lond.), readers in forsenic medicine to the University of London. THE WILLIAMS AND WILKINS COMPANY, 1952. $4.50. 344 pages.

This short book is intended to acquaint the medical student with forensic medicine and toxicology. In addition to the usual discussion of the medico-legal autopsy, chapters on evidence, ethics, legal procedure and the medico-legal aspects of mental disease are included. The section on toxicology is adequate.

The book is of course written with particular reference to medico-legal procedures in England, but its scope is broad enough to interest the American medical student. It is easy to read and does not emphasize technical and laboratory data.

J. C. S.

The Principles and Practice of Medicine. A Textbook for Students and Doctors. By L.S. P. Davidson, B.A.Cantab., M.D., F.R.C.P.Ed., F.R.C.P. Lond., M.D., Oslo. Published by The Williams & Wilkins Co., Baltimore, 1952. Price $6.75.

This is just another textbook of medicine. On the flyleaf it states it is a textbook for students and Doctors. However, it seems it would be more applicable for students. Most likely the English medical student would find it of more value than his American Cousin.

There are relatively few diagrams and one color plate. The type and paper make for easy reading, and the arrangement of material is logical.

J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Operative Gynecology. By Richard W. TeLinde, Professor of Gynecology, Johns Hopkins University and Chief Gynecologist, Johns Hopkins Hospital. 409 figures and 7 color plates. Second edition. J. B. Lippincott Company, Philadelphia, Pa. $20.00.

Essentials of Infant Feeding for Physicians. A Practical Text for Rapid Reference. By Herman Frederic Meyer, A.B., M.D., Assistant Professor, Department of Pediatrics, Northwestern University Medical School, Associate Attending Physician, Children's Memorial Hospital, Chicago, Courtesy Attending Physician, Evanston Hospital and St. Francis Hospital, Evanston, Illinois. Publisher, Charles C. Thomas, Springfield. $7.75.

Pheochromocytoma and the General Practitioner. By Joseph L. DeCourcy, M.D. and Cornelius B. DeCourcy, M.D., Authors of Pathology and Surgery of the Thyroid. DeCourcy Clinic, Cincinnati, Ohio.

Symptoms and Signs in Clinical Medicine. An Introduction to Medical Diagnosis. By E. Noble Chamberlain, M.D., M.Sc., F.R.C.P., Senior Lecturer in Medicine, University of Liverpool; Senior Physician, Royal Southern Hospital, Liverpool; Physician

(*Continued on page* 62)



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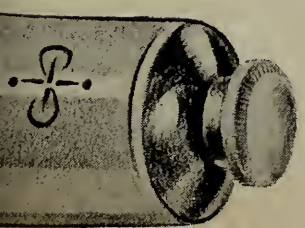
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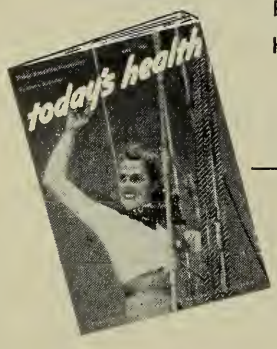
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in Charge, Medical Unit, Sefton General Hospital, Liverpool. Fifth Edition. 354 illustrations, of which 19 are in colour. The Williams and Wilkins Company, 1952. $8.00.

MID-CENTURY PSYCHIATRY, An Overview. Edited by Roy R. Grinker, M.D., Director of Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. 1953. $5.50.

BACK DOWN THE RIDGE. By W. L. White, author of "They Were Expendable". The story of what happens to the men who get "clobbered" in Korea. 1953. $3.00.

RECURRENT DISLOCATION OF THE SHOULDER. By James A. Dickson, M.D., Alfred W. Humphries, M.D. and Harry W. O'Dell, M.D. The Williams & Wilkins Company, Baltimore, Maryland. $4.50.

ENCYCLOPEDIA OF ABERRATIONS. A Psychiatric Handbook. Edited by Edward Podolsky, M.D., State University of New York Medical College. With a foreword by Alexandra Adler, M.D., New York University College of Medicine. Philosophical Library, New York. $10.00.

HISTORY OF ANESTHESIA, With Emphasis on the Nurse Specialist. By Virginia S. Thatcher, Editor, American Association of Nurse Anesthetist Publications. 22 illustrations. J. B. Lippincott Company, Philadelphia, London, Montreal. 1953. $5.00.

FUNCTIONAL DISORDERS OF THE FOOT. Diagnosis and Treatment. By Frank D. Dickson, M.D., F.A.C.S., Clinical Professor of Surgery, University of Kansas School of Medicine; Orthopedic Surgeon, St. Luke's, Kansas City General, and Wheatley Hospitals, Kansas City, Missouri, and Providence Hospital, Kansas City, Kansas, and Rex L. Diveley, A.B., M.D., F.A.C.S., Assistant Professor Orthopedic Surgery, University of Kansas School of Medicine; Chief Orthopedic Consultant, Veterans Administration, Washington, D. C.; Chief Orthopedic Surgeon, Kansas City General Hospital; Orthopedic Surgeon, St. Luke's and Wheatley Hospitals, Kansas City, Missouri, and Providence Hospital, Kansas City, Kansas. 205 figure numbers. Third Edition. J. B. Lippincott Company, Philadelphia, London, Montreal. $6.75.

HORMONAL AND NEUROGENIC CARDIOVASCULAR DISORDERS. Endocrine and Neuro-Endocrine Factors in Pathogenesis and Treatment. By Wilhelm Raab, M.D., F.A.C.P., F.A.C.S., F.C.C.P. Professor of Experimental Medicine and Head of Cardiovascular Research Unit, University of Vermont; Attending Physician, Bishop DeGoesbriand Hospital. Consulting Internist, Mary Fletcher Hospital, Burlington, Vermont, and Placid Memorial Hospital, Lake Placid, New York. The Williams & Wilkins Company, Baltimore, 1953. $15.00.

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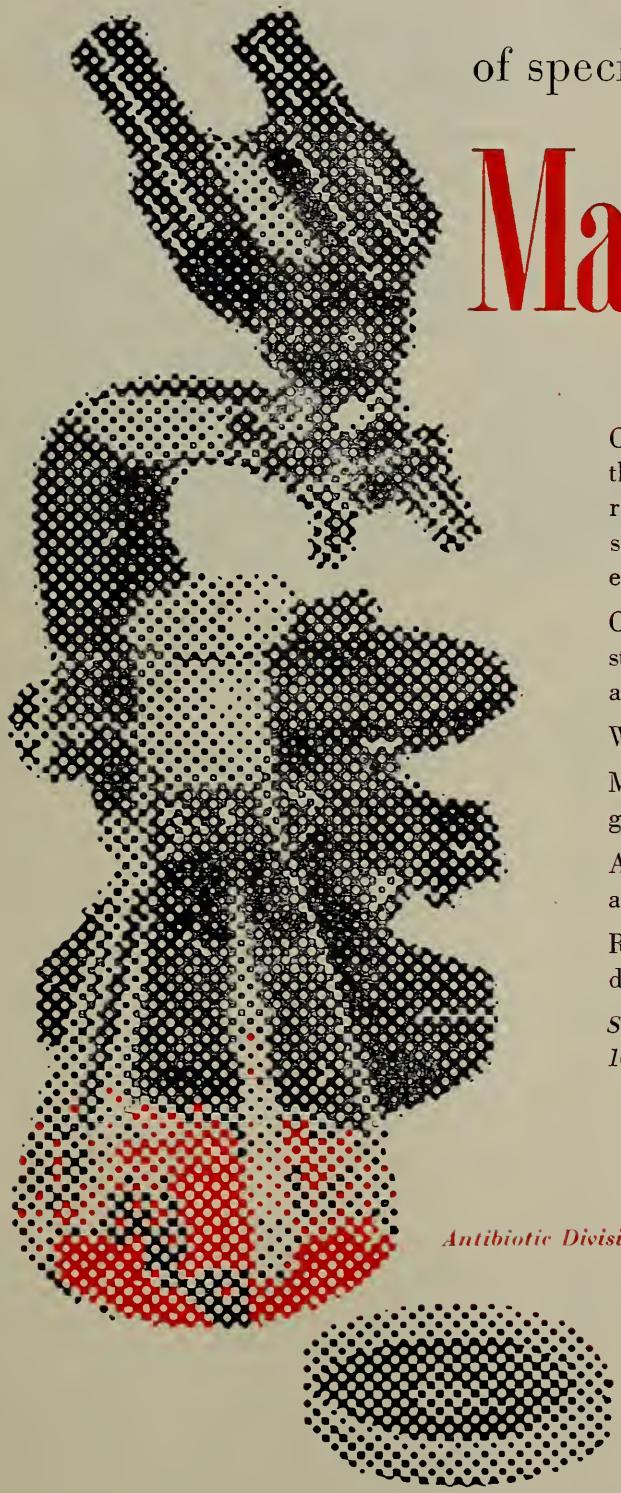
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BULBAR POLIOMYELITIS. By Thomas C. Galloway, M.D., Professor Emeritus of Otolaryngology, Northwestern University Medical School, Attending Otolaryngologist, Evanston Hospital, Evanston, Illinois, Formerly, Attending Otolaryngologist, Cook County Hospital, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. $3.00.

HOW TO IMPROVE YOUR SIGHT. Simple Daily Drills in Relaxation. By Margaret Darst Corbett, Authorized Instructor of the Bates Method. Revised Edition. Crown Publishers, Inc., New York. $1.50.

BEDSIDE DIAGNOSIS. By Charles Seward, M.D., F.R.C.P. (Edin.) Honorary Physician, Royal Devon and Exeter Hospital; Consulting Physician, Princess Elizabeth Orthopaedic Hospital, West of England Eye Infirmary and the Ministry of Pensions; Honeyman Gillespie Lecturer; Late Advisor in Medicine to Eastern Command, India; Deputy President, Review Medical Board, India. With a foreword by Sir Henry Cohen, M.D., F.R.C.P., Professor of Medicine, University of Liverpool. Second Edition. E. & S. Livingstone, LTD. Edinburgh and London, 1952. $3.50.

POLIOMYELITIS. By W. Ritchie Russell, C.B.E., M.D. (Edin.) M.A., (Oxon), F.R.C.P. (Edin.), F.R.C.P. (Lond.) Consultant Neurologist to the United Oxford Hospitals, Consultant Neurologist to the Army, Consultant Neurologist to the Ministry of Pensions, Clinical Lecturer in Neurology, University of Oxford, The Williams & Wilkins Company, Baltimore, Maryland. $3.00.

TEXTBOOK OF VIROLOGY for Students and Practitioners of Medicine. By A. J. Rhodes, M.D., F.R.C.P., (Edin.) Research Associate, Connaught Medical Research Laboratories, and Professor of Virus Infections, School of Hygiene, University of Toronto; Virologist, Hospital for Sick Children, Toronto, and C. E. vanRooyen, M.D., D.Sc., (Edin.), M.R.C.P. (Lond.) Research Member, Connaught Medical Research Laboratories, and Professor of Virus Infections, School of Hygiene, University of Toronto; Second Edition. The Williams and Wilkins Company, 1953. $8.00.

FUNDAMENTALS OF CLINICAL CANCER, With Emphasis on Early Diagnosis and Treatment. By Leonard B. Goldman, M.D., Clinical Professor of Radiotherapy, New York Medical College, Flower and Fifth Avenue Hospitals; Chairman, Tumor Conference and Director. Radiation Therapy Department, Queens General Hospital; Consultant Radiation Therapist, Flushing, Rockaway Beach and Triboro Hospitals, New York City. Grune & Stratton, New York, Publishers. 1953. $8.75.

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THE ORIGIN OF A BONE BANK

In February, 1951, the Birmingham Baptist Hospital installed a top opening deep freeze unit that maintained a constant inside temperature of minus ten to minus thirty degrees centigrade. Shortly thereafter we obtained a lower extremity of a healthy 41 year old white male immediately following amputation just distal to the hip. Soft tissues were removed under aseptic technic. The bone was sectioned into strips approximately three-fourths of an inch wide, and four to eight inches long, including the attached marrow. Bits of each section were submitted for culture in sterile, stoppered, glass tubes. The strips were separately placed in autoclaved. dry. screw

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capped, glass jars and stored in the freeze unit. Most of the bits of bone cultured for a minimum of four days on thioglycollate media showed no bacterial growth. Then, corresponding jars were labeled: "Ready for Use."

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All students are, of course, eager to acquire a big practice. I hope that all of you will attain this goal. However, it will not be many years before you are aware of the fact that mere numbers of patients do not bring the entire satisfaction to a doctor that he has hoped. To be the doctor of many patients is certainly a feeling of trust; to be the doctor of important citizens of the community is a very reassuring endorsement of your ego and with it the hopes for larger practice; but to be the physician of the nurses and doctors with whom you work and to care for their families is an inner satisfaction of professional competence unequalled by money, acclaim, or other honor. *Dean Harold Leuth, This Business of Being a Doctor. South Dakota J. Med. & Pharm., Sept.* 1952.

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In America we are having powerful social repercussions to the Atomic Age. The greatest effects of this social repercussion are upon our young people. Because of the necessity of the draft and of almost universal military service, our young men can no longer make definite or specific plans for their own lives. Education may be interrupted or postponed, careers may be changed or eliminated, and marriage with a home and family and a normal settled life, may be made more difficult or impossible. In addition, there is the threat of death or disability on the field of battle. The young women of our country are affected directly by the predicament of the young men. They must wait to marry, or marry and wait for their men to return to them. In wartime, and to some extent today, there has been much doubling up of families. The housing shortage, or other reasons, have made it expeditious for the wives and children of service men to live with their own or their husband's parents, with many resultant conflicts and maladjustments of one kind or another. All of these conditions induce a sense of futility and hoplessness, and a feeling of confusion and deep resentment in the minds of many of our younger generation. *William Howard Hengstler, M.D., Psychiatric Implications of the Atomic Age. Minnesota Med. May* 1952.

AT THE TURN OF THE CENTURY

In those early days (1900) we were poorly equipped compared with the young doctors of today. In addition we had to contend with unsanitary conditions, ignorance, faith doctors, quacks and even some witchery. We had to educate, plead, and argue and if it had been fashionable in those days, we might have cursed in defense of the principles we believed to be right. There were many ignorant doctors scattered over the state, practicing legally without ever having attended a medical school. There was a time when all they had to do was register with their county clerks as a doctor of medicine and go to practicing. Under such circumstances, we had a great work to do and we have come a long way. Just from my own experience and knowledge, I think it appropriate to designate the last few years of the last century and the first decade of this as an era of purgation and

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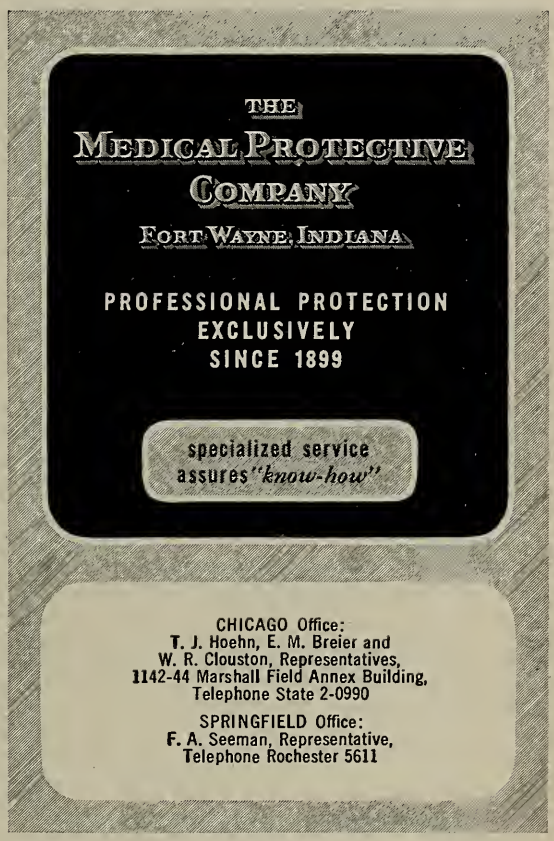
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Both the medical student and the nurse in training must be made to appreciate that tuberculosis work is an interesting and worthy vocation. Too many general hospitals still refuse, or are reluctant to provide, facilities for the modern treatment of tuberculous patients, so that both student and nurse receive only a hazy and remote impression of the subject. This impression can easily develop into the idea that one only does tuberculosis work as a last resort. Frederick Heaf, Editorial, The Lancet, November 3, 1951.



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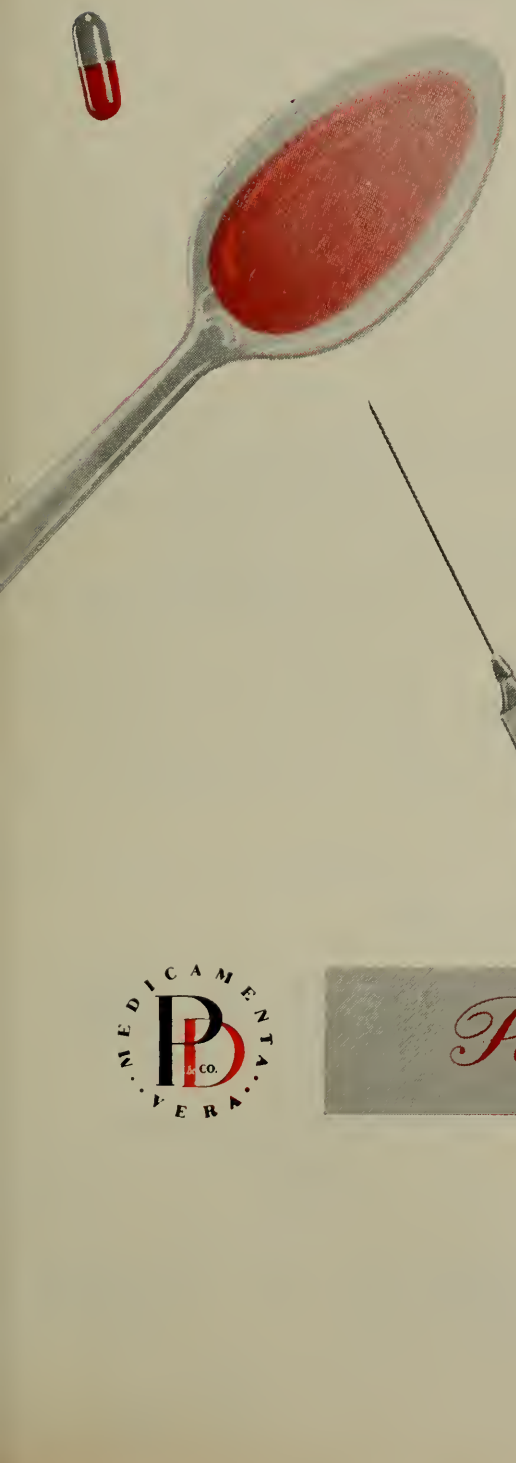
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To help alleviate the shortage of tuberculosis beds, consideration should be given to including beds for tuberculosis patients in general hospitals. Past experience has shown this to be a highly desirable practice. Division of Hospital Facilities, Public Health Reports, July, 1952.

Tuberculosis among diabetics is a special, serious, and integral part of the whole problem of eradicating tuberculosis. The importance of early isolation of the patient with positive sputum should be stressed, as well as prompt hospitalization and institution of appropriate therapy. Reeducating the patient so that he will practice good living habits will do much to prevent future relapses. David A. Cooper, M.D., and Katharine Boucot, M.D., The Am. J. of Nursing, Nov., 1952.

THE QUESTIONABLE CASE OF SYPHILIS

At the present time, the ease with which syphilis may be treated by penicillin and the relative innocuousness of such treatment has led to great carelessness in the proper evaluation of the positive blood test. I shudder at the flippancy with which doctors justify their course of action in the face of positive blood tests of unknown significance. Their reasoning so often follows a line I have heard expressed to me verbally, "Maybe the positive blood tests do not mean syphilis, but I don't know; and giving some penicillin isn't going to hurt the patient. So I am going to treat them." Such malpractice seems a simple answer but the experienced physician will agree when I warn concerning the far reaching serious consequences of making a diagnosis of syphilis. Granted, in many there is no mental trauma but the consultant who has interest in syphilis can cite example upon example in which the diagnosis of syphilis has left a mental scar which cannot be eradicated either by the passage of years or by the repeated reassurance of physician after physician. The embarrassment and guilt, and the phobia of possible late manifestations of syphilis, so frequently discussed in the lay press and magazines, are so impressive that many patients can never shake themselves loose from fear. After repeated negative spinal fluid examinations, some of these patients still go from doctor to doctor begging for "just one more" lumbar puncture in order to be reassured that no disease is present in the nervous system. *R. H. Kampmeier, M.D., Interpretation of the & S.J. Sept.* 1952.

SPECIAL DIET

The term "special diet" is unfortunate terminology which is not compatible with modern diet therapy. All patients are "special" and should have individualized attention. Therapeutic or modified diets should be patterned as closely as possible to routine diets for better patient satisfaction, for psychological reasons, and for teaching the patient. The discharged patient should be able to modify his diet from the family dietary. *Lucille M. Refshauge, Hartford (Conn.) Hospital, quoted in Hospitals, Oct.* 1952.

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*Glazebrook, A. J.: Brit. M. J., 2:1328 (Dec. 20) 1952.

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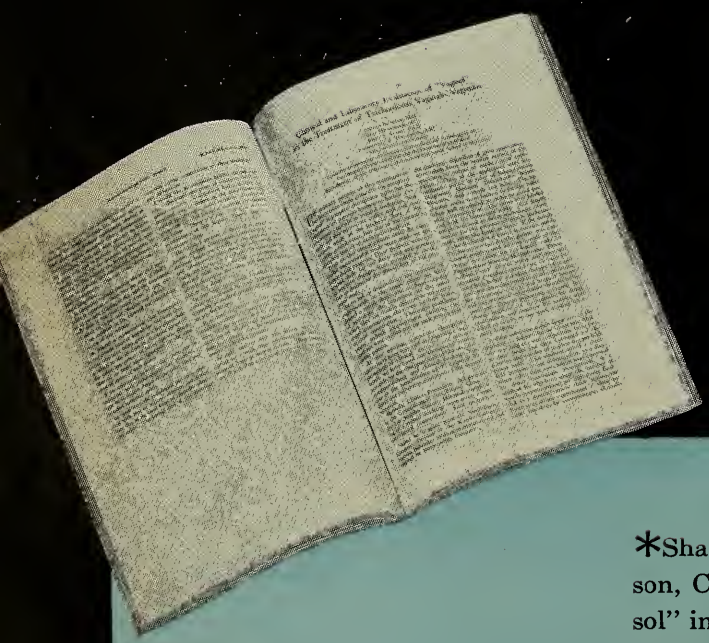
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*Shaw, H. N.; Henriksen, E.; Kessel, J. F., and Thompson, C. F.: Clinical and Laboratory Evaluation of "Vagisol" in the Treatment of Trichomonas Vaginalis Vaginitis, Western J. of Surg., Obst. & Gynec. *60*:563 (Nov.) 1952.

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

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Vol. 103, No. 6 June, 1953

ILEOSTOMY CLUB

During the past 25 years we have witnessed the establishment of hundreds of new organizations, foundations, associations, and clubs with a medical aspect. The American Heart Association, the American Cancer Society, and the National Foundation for Infantile Paralysis are among the largest and best known. Their popularity stems from the intense interest of laymen in helping the medical profession to solve specific problems. There also are a number of lesser known organizations such as the National Multiple Sclerosis Society, the United Cerebral Palsy Association, the Wise Owl Club (to spare eyes from industrial accidents), and the Lost Cord League (laryngectomies).

The latest is the Ileostomy Club, which consists of 50 active members and five officers, all with the same problem. The purpose of the group is to pool their information not only to bolster morale but to help each other in overcoming the stigma associated with the operation. These individuals have learned several lessons and have adjusted so well to their handicap that all patients who have undergone ileostomy will profit by writing to this organization at Mt. Sinai Hospital, New York. The best bags, pastes, cleaning methods, and deodorants are discussed. Since the members learn by doing, many know more than we physicians about the subject.

A HOBBY FOR DOCTORS

In recent years there seems to have been considerable increase in interest in economic problems. There is concern about how to retain part of our earnings for the use of ourselves and our families. How to pass on to our dependents and any property accumulated is another question that engages more and more of our attention.

The federal government is our greatest enemy in our efforts to achieve financial independence. Patrick Henry was one of the first to recognize this possibility. When the Virginia legislature was debating the Constitution Patrick vigorously opposed its adoption. He had two objections: one, that it did not limit the size of the armed forces and, two, that there was no limitation on the taxing power of the federal government.

This journal not long ago carried a splendid article about wills and how wise it is to have one.

The Journal of the American Medical Association last year ran a series of articles by Mr. W. S. McClanahan "Estate Planning for Physicians".[1] Those who haven't read it should do so now.

The Mississippi Valley Medical Society, at

(1) J.A.M.A. April 19, 1952, Vol. 148, pp 1401-1404; May 3, 1952, Vol. 149, pp 59-63; May 17, pp 240-245, and June 7, pp 562-568.

its meeting last fall, had an exhibit by one of the investing companies or investment trusts.

So it seemed well to have a contribution along that line by a physician.

Recently Dr. Vincent T. Williams of Kansas City became editor of the Journal of the Missouri Medical Association. He does not play cards or golf. His hobby is following the stock market. This he has found both interesting and lucrative. So he was asked to write something about his hobby and how he followed it. Below is what he has to say on the subject. Undoubtedly many of us would have been much better off financially if we could have had this advice years ago.

"Physicians have made money out of many commercial adventures and plenty of them have lost their shirts, but to this writer one of the most fascinating hobbies (and not without compensation) has been to follow the stock market.

You will notice we did not use the phrase "playing the market". There is a vast difference.

And here are some fundamentals:

1. Never "put all your eggs in one basket".
2. Don't invest up to the hilt, no matter how good it looks.
3. Never buy on a margin.
4. Patience, patience, and more patience.

Any physician who is just starting needs first, a home; and second, a big insurance program. Most doctors in this class would be better off with a smaller home and a bigger insurance program. Being in the "age of sex", there'll probably be children, so our advice to this group is: A modest home, and twice as much insurance (for the protection of the wife and kids) as you dream you'll ever need.

As this fellow gets a little older and as things level off financially he can start thinking of stocks as a reasonably lucrative hobby. Remembering the four points given above, what stocks?

Here again one is astounded to find all the information needed given freely without "hot tips" and other such spurious help. The bigger, better brokers give away all the data any patient high-school mentality needs to figure these stocks out. And if anyone is interested, studious, and patient, his opinion is worth as much as any of the so-called "experts."

As for text books we would like to recommend "Estate Planning", by McClanahan, a lawyer with the Lake Shore National Bank of Chicago. It is splendid!

Our favorite weekly paid-for journal is the "Financial World", a conservative weekly at twenty bucks a year.

And for back-ground data we buy semi-annually (at three dollars a copy) a booklet which contains some of the most essential data on over 500 commonly-traded stocks from the Securities and Research Corporation, of Boston.

The first brochure mentioned is for free, and individual stock leaflets may be obtained from any reputable broker for free, thus the basic, essential elements for study may be had for twenty-five dollars a year or less — (and it's deductible).

There are many advisory services, some of them darned good. Their charges run from around five dollars a month up to several hundred dollars a year. They are interesting, informative, and add to the reader's background. But they are neither necessary nor particularly helpful.

Most physicians say, "I don't have any time for that sort of business". Of course this is pure, unadulterated hooey. The busiest physician has a few minutes a day which he could allocate to this interesting hobby, if he really wanted to. Actually, about one hour a week, or even less, is all the time required. And it is a hobby which may be followed winter and summer, in good weather and bad, in vigorous youth or decrepit old age, with a minimum of effort, nuisance, and physical or mental strain.

As implied before, we do not advocate a furious "in-and-out" program; these active "traders" are the boys who sometimes make a million or lose their shirts.

But to follow the stock market is a fascinating and worthwhile hobby for the physician who will take the trouble and have the patience to study carefully all the angles."

V. T. Williams, M.D.

Tuberculosis is characteristically slow and insidious in its onset. A disease which has early and dramatic symptoms and makes its victims seek medical advice at once does not present the same difficulties of control as does a disease like tuberculosis. Robert J. Anderson, M.D., Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.



Willis I. Lewis, M.D.

President, Illinois State Medical Society
1953-1954

CORONARY THROMBOSIS WITHOUT THE ANTICOAGULANTS

When should the anticoagulants be used in coronary thrombosis? Drs. H. I. Russek and B. L. Zohman attempted to answer this question at the anual meeting of the American Heart Association last spring, by grouping their hospital patients into two classes: (A) those with a good prognosis and (B) those with unfavorable signs and symptoms. The latter group included patients with previous myocardial infarction, intractable pain, shock, cardiac enlargement, gallop rhythm, congestive heart failure, auricular flutter or fibrillation, ventricular tachycardia, and diabetic acidosis or other conditions predisposing to thrombosis.

This criterion was used on a series of 1,047 consecutive cardiac cases. All were diagnosed as acute myocardial infarction and all were treated by conservative means without anticoagulants. On the day of admission, 489 were placed in the good risk class and 558 were considered poor risks. The mortality rate in the first group was 3 per cent and in the second, 60 per cent. There were four instances of embolism in the good risk class and 59 in the poor risk. Of the 15 deaths in the good risk group, 7 occurred in the hospital within 48 hours. It is impossible to say how many of these lives might have been saved with anticoagulant therapy. It is obvious, however, that if these products are to be used, they should be confined to the poor risk patients where mortality is sufficiently high to justify the additional risk of hemorrhage. At any rate, the figures show that the routine use of anticoagulants in the treatment of acute myocardial infarction is unnecessary and somewhat undesirable.

In the discussion that followed the report, the chief criticism was aimed at the classification of these cases. The opponents maintained that it is difficult to determine on the first day of coronary thrombosis whether the individual is a good or bad risk patient.

CHANGES IN ARMY MEDICAL INTERN PROGRAM

The length of time that Army interns will spend in the different hospital sections or services will be changed beginning July 1, the Education and Training Division, Office of the Army Surgeon General, has announced. The Division explained that the changes are in accordance with the requirements of the Council on Medical Education and Hospitals of the American Medical Association.

Under the new plan, medical interns in Army hospitals will spend three months in Internal Medicine, three months in Surgery, two months in Obstetrics and Gynecology, two months in Pediatrics and two months in a service that they select on the basis of personal preference. Electives open to the interns are Laboratory Service, Ophthalmology Section, Otolarynology Section, and the Physical Medicine, Psychiatry and Neurology, and Radiology Services.

The program currently in effect allows the intern four months in Surgery, including Urology and Orthopedics, four months in Medical Service, including Pediatrics and Contagious Diseases, two months in Obstetrics and Gynecology, one month in Psychiatry and Neurology and one month for an elective chosen from among the following: Laboratory Service, Ophthalmology Section, Otolaryngology Section and Physical Medicine.

A total of 150 medical school graduates will intern in Army hospitals during the year 1953-54. Hospitals participating in the intern program are Army and Navy Hospital, Hot Springs, Ark.; Brooke Army Hospital, Fort Sam Houston, Tex.; Fitzsimons Army Hospital, Denver, Colo.; Letterman Army Hospital, San Francisco, Calif.; Madigan Army Hospital, Tacoma, Wash.; Murphy Army Hospital, Waltham, Mass.; Percy Jones Army Hospital, Battle Creek, Mich.; Tripler Army Hospital, Moanalua, Oahu, Hawaii; Valley Forge Army Hospital, Phoenixville, Pa.; Walter Reed Army Hospital, Washington, D. C.; and William Beaumont Army Hospital, Fort Bliss, Tex.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Public Aid Medical Program

W. Robert Malony, M.D.
Pittsfield

In September 1952 there were 264,056 people receiving Public Aid in Illinois through the State Public Aid Commission. This cost $12,065,402.-43 in tax money and of that amount over $2,-000,000.00 was spent for medical care program.

At a recent meeting of the State Medical Advisory Committee to the Public Aid Commission the question of use of vitamins in public assistance cases was before the committee. To an impartial observer it appeared that this committee gave a very thorough study to this problem, and that they were fully cognizant of the various factors involved. It appeared that the doctors of the committee in no way wished to interfere with the use of vitamins in treating true avitaminosis. However, it was obvious that these doctors were very well informed as to the amount of money available to the Public Aid Commission for use in caring for the recipients under the Medical Care Program. They realize that if all of the money which is appropriated for medical care is used to pay for high priced drugs and for multiple vitamin preparations in treating all patients, then there will be very little money left to pay for necessary hospitalization and necessary charges made by physicians for their care to these people.

It was brought out by one of the members of the committee that when these public assistance programs were first set up, the fee schedules for doctors were very, very low and that at that time the doctors were caring for the patients during a good portion of the time without pay, because the money which was available had been used up. For instance, in the first half of the month all the money was used and then there was none left to pay doctors the last half of the month. For that reason it is necessary that we now be very careful in prescribing vitamins and only in those patients who will definitely require supplementary medication, or who will have a very real chance of improving under such medication. There was some discussion as to the fact that old age recipients do not use the money they get to buy and prepare proper food. This, of course, is a social problem and not a medical problem, if the patient is perfectly able to assimilate and utilize vitamins from natural foods. It is not the place of the doctor to prescribe supplemental vitamins, but rather to have the

patient or recipient instructed as to the procurement and use of proper foods in order to get the necessary vitamins.

The costs of medical care for the people under the supervision of the Public Aid Commission has risen tremendously in the year starting July 1, 1952. The costs for the first five months of the 1952-1953 fiscal year are approximately 60% higher than they were for the fiscal year ending 30 June 1951. Some place among the various charges and possibly in all categories there has been a very real increase in cost. The members of the committee felt that this situation had to be taken into account, in the judgments that they rendered in regard to their various problems. In any programs set up to use public funds for providing services for citizens, the possible benefits to the citizens must be limited by the amount of funds available under that program. Since this truism is understood by all, it follows very simply that when the cost of individual items in the budget raise, then there must be of necessity additional regimentation, as to the dispensing or prescribing of those items to the recipients. There can be only one result: the services will be more closely scrutinized, and there will be increasing regulation of the services rendered. The doctors will be in this way more closely supervised and there will be additional rules as to services which must be limited or must not be given at all. This is the only result that can come from increasing cost for this care.

However, the members of the Medical Advisory Committee at the state level feel that they are rendering a very real service to the physicians of this state. During the entire program, up to this date, they have been able to keep the medical care under the supervision of the physicians of the state. They feel that this is a real benefit to the patient and is also a benefit to the physicians who participate in the program. They hope that the physicians participating on a local level and at a county level will attempt to understand their problems at a state level and as a result will try to cooperate as closely as possible. In all of the various phases of this program, they feel that it would be very undesirable from the standpoint of the patient and the physician, if this supervision of medical care were taken out of the hands of physicians. For that reason they are making every effort to cooperate with physicians at all levels.

As a matter of fact, over a period of the last couple of years these doctors have extended invitations to several members of County Advisory Committees, and request their attendance at the State Advisory Committee meetings. In this way, they hope that the local boards will be able to understand the problems at state level in a more efficient manner. They also wish that the information which they occasionally have published in the Illinois Medical Journal was read, and understood by more of the members of the Illinois State Medical Society. They feel that they are attempting in this way to disseminate information, and they feel that very often the information is not obtained, simply because the local physician doesn't bother to read the article or the note which is there for his information.

119 S. Monroe St.

AIR TRAVEL

The transportation by air of patients with cardio-pulmonary disease is satisfactory and usually agreeable, provided the distance is sufficient to justify the long trip to and from airports. In any event, traveling should be in pressurized cabins only, since the higher barometric pressure of the ordinary types may cause symptoms of oxygen lack. The contradictions to air travel are cystic disease of the lung, recurrent spontaneous pneumothorax, high pressure artificial pneumothorax, acute upper respiratory tract infections with exacerbations of chronic lung disease, manifest coronary insufficiency, failure of the right side of the heart, and recent hemoptysis. *Burgess Gordon, M.D., Selection of Patients With Cardio-Pulmonary Diseases for Air Travel. Philadelphia Med., Aug.* 30, 1952.

CORRESPONDENCE



UNIVERSITY OF MICHIGAN SIXTH ANNUAL CONFERENCE ON AGING

"Careers for Maturing Workers" is the theme of the University of Michigan Sixth Annual Conference on Aging to be held in Ann Arbor, July 8-10, 1953.

The problems associated with earning in the later years and with methods for creating new opportunities for remunerative activity by aging people are particularly pressing at this time because of the steadily increasing number of older workers cut off from earning opportunities.

Discussion sections led by nationally known experts will consider:

Economic, social and personal values of continuing employment

The maturing worker from the standpoint of health

Age, skill and motivation as factors in adjustment of the older worker

Counseling, guidance, placement and training of the maturing worker

Continuing employment in business and industry

Practical considerations in specific fields of work including arts, crafts, manufacturing and service occupations

Development of new opportunities in all fields of work

Needed action by business, industry, unions, communities and government agencies

Conference membership is open to anyone but will be of special interest to:

Social planners

Employees and personnel workers in business and industry

Employment counselors and placement officers

Industrial and geriatric physicians

Legislative groups

Arts and crafts groups

Educators

Buyers and marketing personnel

Chambers of Commerce

Agricultural and farm groups

and

Older people themselves

Exhibits and demonstrations of marketable skills will be a feature of the Conference.

For further information about the program write to: Wilma Donahue, Chairman Division of Gerontology, University of Michigan, 1510 Rackham Building, Ann Arbor, Michigan.

ANNOUNCEMENT OF INSTITUTE

The Board of Trustees of La Rabida Sanitarium, Chicago, announces the inauguration of an annual institute in the field of rheumatic fever. The institute will be held for the first time on October 12, 1953, and on that date thereafter or the first Monday which follows October 12th. This is the anniversary period of

the opening of the hospital on October 21, 1932, Columbus Day (October 12th), St. Luke's Day (October 18th), and the anniversary of the Variety Club (October 11th).

The Trustees will dedicate also at that time, on October 16th, the new Gertrude F. Pick Memorial Center for community service in rheumatic fever. Friday, October 16th, 1953 has been designated as Robert A. Black Day, and a lecture in Doctor Black's memory will be inaugurated on that day.

The institute will be educational in character and will cover the subject of rheumatic fever and rheumatic heart disease. It will be conducted for four days by members of the hospital staff, together with others selected from the medical school in this city with which the hospital is affiliated, and by several invited guests. It will be directed primarily to the general practitioner or family physician and to nurses, medical social workers, occupational therapists, dentists and others with a similar interest in the subject. There will also be a scientific session. Sessions will be provided also for the public, especially patients and their parents.

Advance registration will be required for those who wish to attend the entire five-day session. Attendance will be open to all these groups and will be limited only by the size of the building to accommodate those who attend. Visitors to individual sessions will be admitted by card on previous application. There will be no admission or tuition charge.

Further information will be supplied by circular or application to Institute La Rabida Sanitarium, East 65th St. and South Shore Drive, Chicago 49, Illinois.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR JULY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the July schedule of clinics for physically handicapped children. The Division will count 21 general clinics providing diagnostic orthopedic, pediatric speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July clinics are:

July 1 — Hinsdale, Hinsdale Sanitarium

July 2 — Sterling, to be announced prior to clinic

July 3 — Evanston, St. Francis Hospital

July 7 — Flora, Clay County Memorial Hospital

July 8 — Joliet, Will County T.B. Sanitarium

July 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

July 9 — Cairo, Public Health Building

July 9 — Springfield, St. John's Hospital

July 10 — Chicago Heights (Rheumatic Fever), St. James Hospital

July 14 — East St. Louis, St. Mary's Hospital

July 14 — Danville, Lake View Hospital

July 14 — Peoria, St. Francis Hospital

July 15 — Evergreen Park, Little Company of Mary Hospital

July 15 — Alton, Alton Memorial Hospital

July 21, Macomb, Marietta Phelps Hospital

July 21 — Salem, American Legion Hall

July 22 — Aurora, Copley Memorial Hospital

July 22 — Springfield (Cerebral Palsy), Memorial Hospital

July 23 — Bloomington, St. Joseph's Hospital

July 23 — Rockford, St. Anthony's Hospital

July 23 — Mt. Vernon, Masonic Temple

July 24 — Chicago Heights (Rheumatic Fever), St. James Hospital

July 28 — Effingham (Rheumatic Fever), Douglas Township Building

July 28 — Peoria, St. Francis Hospital

July 28 — Quincy, St. Mary's Hospital

July 29 — Carrollton, Grade School

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

ORIGINAL ARTICLES



This I Believe

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When I was in grammar school in North Dakota, the teacher tried to teach us elocution -- and I did my best to avoid learning it. I can still remember the time I was supposed to memorize the Gettysburg Address and recite it before the class. Of course, I realize now that Lincoln's great words were worth learning, whether or not I learned much about elocution, but at the time I was just concerned with avoiding the memorizing. For a week before I was supposed to recite, I spent my evenings copying that short speech on a pencil. When the day came, I stood up before the class, nervously turning the pencil in my hands as I read the speech from it. Of course, the teacher got suspicious — maybe because I seemed to know it so well — and confiscated the pencil. I stayed after school that night until I had really memorized the whole address.

I continued resisting courses in elocution and public speaking throughout my school days, though I regret it now — and maybe you do too. What I am going to say now, therefore, will not be a high-flown piece of elocution about the future of medicine and our Society, but a simple statement of my beliefs concerning the medical profession in this country today, based on my own observations and experience in almost thirty years of medical practice.

This I believe — that we doctors sometimes spend too much time looking into the past with rose-colored glasses and not enough time looking at the world around us. Regularly I hear or read some doctor wishing for the "good old days" of the "good old family doctor", the "horse-and-buggy physician". Now, seriously, I think none of us would really want to go back to those "good old days", say to the turn of the century. Think for a minute about the lack of equipment we use everyday, the comparatively inadequate medical education, the lack of hospital facilities. Consider the transportation: the horse and buggy could travel some roads a modern car couldn't, but five miles was a great deal longer in those days. Think of the drugs we use now that weren't even imagined then. And I believe very few of us would really prefer doing emergency operations on a kitchen table, no matter how well scrubbed it was.

Of course, there is one sound basis for this

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nostalgia. What we really look back to is the relationship between the patient and his doctor. It seems to us now that, in those days, the physician was looked up to as a person, whereas now he is looked up to as an expert on medicine. That is the great, impressive thing in all the stories about the old family doctor: the respect, the honor he had in the community — and it is that respect and honor, as individuals, that we seek as one of the crowning glories of our profession.

This I believe — that most doctors chose their profession because they wanted to serve humanity, because they wanted to ease some of the suffering of the world, because they wanted to help their fellow-man. These are the motives of every physician worthy of the name. And one of the greatest rewards a doctor can have is the knowledge that he is respected, yes, and loved by the people he serves; that the community in which he works feels he *has* helped them. This knowledge is something that cannot be evaluated in terms of money; the richest physician, without the feeling that he is honored as a man, is poorer than a struggling young resident, just setting out on his medical career.

Yet today, it sometimes seems that physicians are not only not respected but actually disliked. I don't mean that the individual physician is disliked, but the profession as a whole.

During the past few years, there have been a number of surveys made concerning what the layman thinks about doctors. It is interesting to note that, whenever a complaint is made against the profession, the complainer's own doctor is usually excepted. For instance, one person interviewed will say, "Doctors charge too much. Of course, my own doctor's fees are pretty fair, but most doctors will take as much as they can get." Or "Doctors just think of their patients as cases, not as people. Of course, my doctor is really interested in me as a person, but he's different."

I think it is important for us, as physicians, to find out why so many people have a low opinion of the profession as a whole, in spite of their liking for individual doctors. It is important for two reasons: we must have public support if medicine is to remain free in this country and, perhaps more important, it is difficult to treat a patient effectively if he starts out disliking you. As I understand it, psychoanalysis has a rule that antagonism between patient and analyst can make treatment impossible. The same thing applies to medicine generally, though perhaps not so obviously. I think you all know how difficult it is to really help a patient who doesn't trust you or who doesn't like you or who doesn't really think you can help him.

It isn't just in the surveys that I come across these signs of antagonism. Think back over the news stories about doctors you can remember recently — how many of them were about good doctors, men who had devoted their lives to serving humanity, and how many were about scandals in the medical profession? And which type of story got the bigger write-up?

Of course, a scandal, nowadays, makes a better news story than praise of someone, it sells more papers, but, allowing for that, the trend seems to be definitely against us. The number of medical societies emphasizing their public relations programs today is another sign — because, sadly enough, most of us don't start worrying about our public relations until we notice they're getting a little sour.

This I believe — that if we wait until the last minute to wonder what's wrong, it will be too late.

I think our nostalgia for the "good old days" is a clue to the problem. The world has changed greatly in the past fifty years, and not only the world but the people in it. The patient has changed, and so has the doctor. Sometimes, it seems to me, we trend to notice only how much everyone else has changed and to ignore the change in ourselves.

I have already mentioned some of the changes in the practice of medicine — but I have only talked about changes in equipment and facilities. Let's consider for a minute the change in the physician himself.

We spend much more time nowadays in learning our profession — in fact, most of us feel we should never stop learning. We have scientific meetings, we attend postgraduate courses and lectures; we continue the study of medicine all our lives. But, even when we are in medical school, we take more courses, we study more intensively, we discover more things we must know

before we can consider ourselves qualified to practice.

What is the result? I think many of you will agree that it means a sacrifice of much of our personal life to medicine. Think back to the close friends you had before you started medical school — isn't it true that, when you entered medical school and they didn't, it was as if the road you had in common before forked in two directions? Isn't it true that, the further you went in medical school, the farther your road forked from your old friends?

Of course, we try to keep in touch with our old acquaintances; we get together, when we can, for a "remember when?" session; but how much have we in common with them besides the old times?

The point I am making is this: the more complicated, the more technical a profession becomes, the more the man who wants to master that profession must immerse himself in its learning. And we have only a limited amount of time in each day; the more hours our profession demands, the less time we have for anything else — and the more distant we grow from those outside the profession.

This is true not only of physicians. In all the scientific professions, which have grown immensely more complex in recent years, you will find men who can converse comfortably only with fellow scientists. The professional musician sometimes finds difficult talking to those without a musical background; the lawyer is more at ease in the company of lawyers.

So, because we must devote more of our time and energy to medicine, we are likely to devote less of that time and energy to social meetings with laymen. Sometimes it must seem that all we have in common with those outside the profession is the golf course.

This I believe — that the very increase in the complexity of medicine, the very increase in our knowledge of the cause and cure of disease, is one of the factors widening the gap between layman and physician.

Another factor is the change in our country. In the last fifty years, this nation has grown continuously more urban; in the last census, of our hundred and fifty million people, over ninety-six million, almost two-thirds, lived in urban areas and less than twenty-four million were living on farms. And the physicians have moved to the cities in even greater numbers than the rest of the population.

It is a pretty obvious rule that the smaller the town, the better the people know each other. So, as the country grows more urban, the doctor and his patient see less and less of one another. In our large cities, for instance, the doctor may have his office in town and his home in the suburbs; he may see his patients only during office hours and at the hospital.

The result is that the patient comes to think of his physician as a doctor only, not as a fellow citizen. It becomes difficult for the patient and doctor to see each other as persons; the doctor is more likely to consider his patient as "a case" and the patient to consider his doctor as merely an expert to be called in when the machinery goes wrong.

Yet this attitude is not only bad for the medical profession as a whole, but it is also harmful to the practice of medicine itself. Many medical writers have pointed out in recent years the danger of considering the patient merely as a "case"; we have been told over and over that we must treat the "whole person". These writers often do not seem to realize how difficult it is to *know* the "whole person" in this compartmented world in which we live.

Few of them, also, seem to have noticed the opposite side of the coin: for the most effective medical care, the patient should not consider the physician merely a technical expert, a craftsman. You cannot call in a doctor like you call in a plumber to repair a leak; for truly effective treatment, the patient should have some knowledge of the doctor as a "whole person". The patient may be able to describe his physical symptoms to this expert, identified by the "M.D." after his name, but it is not so easy to detail the emotional, the financial, the social environment which may be partly the cause of these symptoms, to a man who is almost a total stranger.

I believe that the increasingly impersonal relationship between physician and patient can not only affect the reputation of the medical profession but also make medical treatment itself less effective.

There is another factor, which has been barely indicated in the surveys, but which may grow more important as time goes on. The United States is becoming one of the most highly edu-

cated countries in the world. For a nation this size, the rate of illiteracy is amazingly low; no other nation has so many citizens with at least some higher education. For that matter, no other nation has so many college graduates.

There is one very simple indication of the result of this mass education on physician-patient relationships. In several recent polls, some of those questioned have shown a dislike of the term "laity" for those outside the medical profession. An even larger number have expressed their annoyance with doctors who refuse to explain what their illness is or the purpose of treatment.

In general, they say: "I go to the doctor to find out what is wrong and what to do about it. And what happens? He make some tests, looks at x-rays, says 'Hmmmh' and hands me a prescription, which no one but a druggist can read. Then he says, 'Now, you just take this for a week and you should be all right.' If I ask him what's wrong with me, he says, 'Now I'm the doctor — let me worry about that.'"

The only difficulty is that the patient is also worried about what's wrong; that's why he made the appointment. He feels that he is old enough and intelligent enough to understand a simple explanation of what ails him and of the treatment prescribed, even though he may not be able to understand all the details. He doesn't like being treated like a child, and this is just the way some doctors treat him. So he goes to another doctor, one who will tell him what ails him.

When the general level of education was lower, this particular "bedside manner" was less resented. Often the only educated man in town were the doctor, the judge, the school-teacher and the clergyman, and the majority of the town's books were in their libraries. The patient, who might not have finished grammer school before he went to work and whose reading stopped with McGuffey's Reader, accepted the fact that the doctor knew best, without requiring an explanation.

Today, however, the average man is deluged with medical information and misinformation every day of his life. He reads medical columns in his newspaper, medical articles in his magazine; the radio brings him dramatic highlights in medicine, fund campaigns to fight various diseases, and, of course, a huge amount of highly impressive data by means of commercials on everything from vitamin deficiencies to the beneficial effects of tobacco on the throat and lungs. He has a large medical vocabularly, even if he is not quite sure what it means, and he thinks he is entitled to know if the sore on his face is acne or cancer.

This I believe — that if the medical profession is to keep the high place it has kept and deserved throughout history, the physician must recognize the changed world he is living in, rather than look back to an era that shows little sign of returning. In this changed world, he will find a change in his education, in his practice, and in his patients, all affecting the esteem in which he desires that the profession be held.

The basic need, as I see it, is that the physician know, and be known by his patient as a person — not merely as technical expert and problem to be solved.

This is not, I realize, an original contribution. It has been said often in recent years; it has become a slogan, "The best public relations are personal relations." However, the fact that it has been said before does not make it less true. If each doctor does his duty as a doctor to the best of his ability, there will be little call for grievance committees and emergency call plans and press agents; each doctor represents the medical profession, and the medical profession is judged by his actions.

However, I do think it has been underemphasized that "doing one's duty as a doctor to the best of his ability" means more than treating a case as well as possible and setting fees as fairly as possible. It is also true, though frequently neglected, that a good doctor should be a good citizen.

The members of certain professions and trades are not allowed to have a private life. The policeman, for instance, is expected to be as spotless in his private life as he should be when on duty; if an Army officer is drunk and disorderly, even while off duty, it is considered a reflection on the uniform. A lawyer is expected to be as careful of the law in his personal life as when he is arguing a case in court. The doctor, also, is thought of as a doctor at all times; if he is extravagant in private life, it is not John Jones or Leo Sweeney who is extravagant — it is "doctors".

A doctor, therefore, is not only his own first public relations man, but he is also the representative of every other doctor. We are judged by the actions of a doctor in South Dakota and one in Vermont and one in California — and they are judged by our actions.

If we decide that there are enough voters without us; if we decide that our fellow-citizens can carry on the affairs of the community without our help — it affects not only our own reputation, but the reputation of the whole medical profession.

Plato said: "The punishment suffered by the wise who refuse to take part in the government is to live under the government of bad men." The medical profession made a fine showing in the recent presidential election — and I am not talking so much about the results of that election as about the number of doctors who took part in it. The American Heritage Foundation, one of the main agencies working to get out the vote, has even presented awards to the A.M.A. and at least one state medical association for their efforts in getting members to the polls.

However, though we may pride ourselves on the high percentage of physicians who voted last fall and on the campaign conducted by the whole medical profession to persuade every eligible voter of the importance of casting his ballot, we should not forget that, in America, the voter is boss all year round, every year.

The presidential election gets vastly more attention in the newspapers and is, usually, a more dramatic event than local contests. However, if all the voters concerned themselves with their duties as citizens only once in every four years, our democracy would not last very long.

This I believe — that our nation is kept alive and strong by the men who are citizens all the time, the men who do not feel that their only duty is the choice of a president. A democracy must be strong from the ground up; the village, the township, the city, the country, the state governments all must be alive — must be the concern of all their citizens in order that the nation survive and remain free. In the world we live in today, we cannot turn the whole job over to our elected representatives, no matter how effective they may be.

I would like to quote here from a speech made by the great jurist, Judge Learned Mand, just before the last national election. Speaking of the Bill of Rights and of actions against those rights, Judge Mand said that the courts will not intervene unless the action is obviously unconstitutional. "And so it results," to quote the judge's own words, "that in much the larger part of such controversies it is the voters, speaking through their delegates, who have the final word and the final responsibility; and that in the end it is they and they alone, who can and will preserve our liberties, if preserved they are to be. For their guidance there are no *vade mecums,* no handbooks, no manuals; they must depend upon such enlightenment as they can muster from within, and upon their conscience, so far as they have one."

It would be hard, I think, to improve on Judge Mand's statement of the power and importance of the voter. In these trying times, it might well serve as the basis of a motto, to be remembered and repeated daily: "If our liberty is to be preserved, we must preserve it."

Our liberty, both as physicians and as citizens of these United States, is far too important a thing to turn over entirely to some caretaker, with instructions not to bother us about its upkeep. The preservation of that liberty is an every-day, not just an election-day business. Every bill considered by the national or state Congress, every treaty signed, every action of our local township board may have an enduring effect on our professional and personal lives. We can't sit back and say, "Let George do it", because George may not believe in the same things we do.

Before I go any further, I would like to make it clear that I am not talking partisan politics. One of the arguments for President Eisenhower's election was the necessity of keeping the Republican party vital; for the two-party system to be effective, both parties must be strong and both must represent large sections of the population. This is still true after the election; the Republican majority does not require that Democrats give up their interest in the government. What I have said applies to all of us, on both sides of the political fence.

This I believe — that it is not only the right, but the duty of every citizen to be constantly concerned with and aware of the way he is governed, and to do whatever he can to make cer-

tain that it is the right way. The man who neglects his duties as a citizen is out of place in a democracy.

Certainly, if our long years of education have amounted to anything more than attendance at a trade school, *we* are as well qualified as any and better qualified than most of our fellow-citizens to take part in government. We have not only education, but also a long tradition of freedom and self-government; our constant struggle to keep the practice of medicine free should make us all the more eager in the greater struggle for freedom. If liberty dies everywhere else, is it likely that it will long survive in our profession?

Some doctors, I know, feel that taking any prominent part in community or civic activities, particularly political ones, is skating close to the thin ice of unethical advertising. Perhaps a few physicians might use such activities as a way of playing up their own merits; however, for most of us, it is difficult to see how being a good citizen could be considered unethical.

If we are really working for the good of the community, we will be demonstrating our merits as citizens, not our ability as physicians. Yet, at the same time, we will be demonstrating also that our membership in the medical profession has not withdrawn us into an ivory tower, that it has not drawn a line between us and the rest of the community.

In fact, one of the common complaints made about us is that we have no interest in our community, that we are interested only in our profession. Our more bitter critics say that the only time we are interested in government is when it affects us directly. The doctor, they say, fights like a Trojan at the least suggestion of government control of medicine, but government control of business or government control of labor doesn't interest him at all.

Now we could, of course, point out that such an attitude is not confined to doctors. There are a great many people who complain bitterly about taxes, but are perfectly willing to accept what those taxes buy. There are, for instance, a number of newspapers which argue that government should be put on a pay-as-you-go basis — except that the special mailing rates for newspapers shouldn't be changed.

But saying "You're another" is not the answer. If we are not concerned with government infringement on the rights of others, we should be; an attack on freedom anywhere is an attack on freedom everywhere.

I do not want to imply that I think the doctor's only interest in civic affairs should be political; far from it. Taking part in political affairs on the community level is the duty of every citizen, and a good doctor should definitely be a good citizen. However, there are other community interests with which the physician should be concerned, just because he is a physician.

We all know that there is much more to making and keeping a community healthy than what goes on in the doctor's office and in the hospital. A lot of different agencies are surveying the health scene these days, but they all seem to be concentrating on how to get medical care and how to pay for it.

For instance, consider the report of the Commission on the Health Needs of the Nation. I am not going to go into a discussion of the report today, but I think it is important to point out that the main things the Commission studied were the supply of medical personnel and facilities and the various methods of financing medical care. Now, those are important things to study, but they give only a partial view of the question.

For one example, what would you do with a community which had an adequate supply of doctors, a good hospital, prepayment plans and all the necessary equipment for good medical care — but no one using the personnel and facilities until they were too sick to do without them? Wouldn't you say that this community needed some health education, some encouragement to go to a doctor before the last minute?

Consider some of the problems which confront a community: sanitation facilities, school health, indigent care, fluoridation of water, maternal care. Shouldn't a doctor living in the community be actively concerned with the way these problems are solved?

Consider the educational facilities of the community. If the schools are inadequate, shouldn't the doctors be worried — not only for their own children, but because they, themselves, bear witness to the importance of good education? If the community has no library, shouldn't the doctor who treats the whole man be concerned about the stunted mentalities likely to result?

In the same way, it seems to me that the

physician, of all men, should realize the importance of proper recreational facilities for the young people growing up in the community. Juvenile delinquency should be a personal concern to him; he should understand better than most the problems of the blind, the disabled, the aged.

For that matter, consider the various community agencies in operation today: the cancer societies, tuberculosis studies, polio foundations, and all the other organizations dedicated to the study of the diseases which ravage our civilization. It is true that the physician usually helps in the actual work of these agencies, but how often is he one of the founders — how often does he act as a guide and a leader as well as a technical assitant? Yet isn't the doctor the person who should be most eager to discover and to combat disease in his community?

You will notice that each of these interests I have mentioned would require the individual doctor to volunteer his services in some way — not to wait until the job seeks him but to leave his office and find the job, or even to discover work to be done where no one noticed it was needed. As an old Army man, I remember the traditional advice, "Never volunteer for anything." However true that may be in the Army, in other situations the work we volunteer for is often the most rewarding. A hobby, for instance, is work we volunteer for; no one comes to us and begs us to become camera-crazy or to engage in the eminent art of philately — and, because we chose it ourselves, it becomes all the more interesting.

To volunteer for work in your community, to become a full-time citizen, is also rewarding. To see, as a result of your efforts, the place where you live become a better place to live can give you a glow that will last for years; to know that you have had a hand in making your fellow-citizens healthier and happier, to know that the coming generation will be wiser or better adjusted through your efforts is a very wonderful thing, worth all the effort you have spent.

It is rewarding in another way, in addition to the feeling of personal accomplishment and the feeling of fuller participation in the life of your community — which is itself very pleasant. It is rewarding, to return to my starting-point, to the medical profession as a whole.

If we are, as it seems, in a period of our history when the public lacks confidence in us — not in any particular doctor, but in the medical profession as a whole — at least part of the reason is the fact that a gulf exists between the physician and his patient. The gulf exists not so much in professional contact between the two but in social. To the patient, we seem concerned only with medicine; we seem to lack interest and knowledge in regard to anything outside our profession.

The gulf is one that only the doctor can bridge. The community cannot enter the doctor's professional life; he must enter more fully the community's life and, by doing so, demonstrate what he professes — that the physician is concerned with the whole man.

I know that many of us feel that we are too hard-pressed for time now, that we have no energy left for civic or community affairs. Yet history, past and current, tells us that the leaders in any field are the men who can always find the time and energy for something really important. In this day and age, and in this "last, best hope of earth," what can be more important than accepting our full responsibility as physicians, as citizens, as defenders of liberty?

This I believe — that if the physician, maintaining his professional standards and the high quality of American medicine, can also become a full-time, active citizen of his community, his state and his country, the medical profession will attain a rebirth and an increase in respect and confidence beyond anything it has yet achieved in history.

So help us God.

Surgical Correction of Certain Gastrointestinal Abnormalities in Infancy

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Rare anomalies of the gastrointestinal tract in the newborn such as atresia of the esophagus and bowel attract a good deal of attention because of their spectacular nature. There is another important group of gastrointestinal abnormalities that occur in infancy that are to be considered in this paper — hypertrophic pyloric stenosis, malrotation of the intestine, and intussusception. These conditions manifest themselves in infancy and rarely are found in later life. Each presents a definite diagnostistic pattern and all three require prompt and proper surgical treatment.

Hypertrophic pyloric stenosis.—The cause of the hypertrophy of the pyloric muscle is unknown. A typical case feeds normally after birth but at the age of 2 to 6 weeks the child begins to vomit. This vomiting becomes more persistent until all feedings are regurgitated with projectile force, the stools are scant and the child developes dehydration. The vomitus usually consists of partially digested formula and practically never contains bile. Examination reveals the peristalic waves of the dilated and hypertrophied stomach passing across the abdomen from left to right after feeding. The key to the diagnosis is the palpation of the firm, olive-pit sized tumor mass of the hypertrophied pyloric muscle in the right upper quadrant. This is best felt after a feeding or after the child vomits and is completely relaxed. It may require frequent examinations before the tumor is felt. The mass is usually rather superficial and must be differentiated from the border of the rectus muscle, liver edge, lower pole of the kidney or the transverse vertebral process.

The presence of a pyloric tumor establishes the diagnosis. The absence of a tumor after repeated examinations under favorable circumstances casts doubt on the diagnosis. X-ray examinations with a barium meal are required in these doubtful cases. They should show a persistent high grade pyloric obstruction with a marked narrowing and elongation of the pyloric canal.

The differential diagnosis includes simple feeding problems, allergies, pylorospasm, kidney pathology and intracranial pathology. In the problem cases intravenous pyelogram and subdural taps are usually done. G.U. anomalies producing hydronephrosis can give rise to severe vomiting due either to reflexes or pressure from the dialated kidney pelvis or from uremia. A chronic subdural hematoma from birth trauma can also produce projectile vomiting.

When the diagnosis is established surgery is always indicated because attempts at medical management are attended by higher mortality and morbidity. Twenty four hours or more may be required to get the child in good hydration and electrolyte balance. It has become routine to obtain preoperative levels of CO_2, Chlorides, and pH of the blood. Difficulties during and after the operation are largely avoided if these precautions are taken. Usually a hypodermoclysis of physiological saline solution will suffice but if alkalosis is marked 1/6 Molar Ammonium chloride solution must be given intravenously.

Operation consists of making a small longitudinal incision in the right upper abdomen lcm. to the right of the midline. If the incision is made over the liver closure of the peritoneum is facilitated and evisceration is prevented. The rectus muscle is spread longitudinally, in the direction of its fibers, and the posterior sheath and muscles are split transversely. When the peritoneal cavity is entered the liver can be retracted upward and the stomach grasped and brought out of the wound. The pyloric muscle tumor is readily identified and a longitudinal incision is made in the least vascular portion through the serosa and partially into the muscle. These pale, tough muscle fibers are then spread until the mucosa bulges into the incision. Great care must

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be taken to spread the fibers at the duodenal end. If even a few tough fibers are left unspread the child may vomit postoperatively. If the delicate duodenal mucosa is torn it must be instantly recognized and the opening closed. The stomach is returned to the abdomen and the wound closed.

Six hours postoperatively the child is started on a drachm of water by mouth increasing the amount every hour and alternating with dilute formula. If vomiting of a feeding occurs the amount given the next hour is reduced to that which the child had previously been able to retain. After one ounce can be retained the normal formula and feeding intervals are resumed. These Children rarely regurgitate postoperatively and can usually go home in 4 or 5 days. The operative mortality should be very low and no recurrence of symptoms are to be expected.

Malrotation of the intestines.—With incomplete rotation of the bowels the cecum usually lies in the right upper quadrant and becomes attached by fibrous bands across the duodenum to the region of the gallbladder and posterior abdominal wall. The small intestines on a narrow pedicle of mesentery usually undergo volvulus which not only impairs their blood supply but also obstructs the duodenum by tightening the adhesive bands.

The infants with severe obstruction of the duodenum begin vomiting shortly after birth. The vomitus, unlike that in pyloric stenosis, contains bile and the child is likely to go into fluid and electrolyte imbalance very quickly.

At times the obstruction is intermittent and the patient may reach several years of age before the condition is recognized. One 5 year old patient had had repeated attacks of vomiting since birth variously labeled as feeding problems, colic, gastroenteritis and finally a behavior problem until one acute attack brought her to the hospital and the malrotation was discovered and corrected.

Physical examination is usually not very revealing but an upright x-ray film of the abdomen shows a dilated stomach with an air bubble in the fundus and a second smaller air bubble in the dilated first portion of the duodenum. Two other x-ray examinations are important. A barium enema will show the cecum in the right upper quadrant and barium or iodized oil given by mouth shows the dilated duodenum with only a thin stream of barium passing into the 3rd portion of the duodenum.

As soon as the diagnosis is established surgery must be performed as quickly as the child can be gotten into satisfactory condition for operation. A generous paramedian incision is made and the intestines brought out of the abdomen and carefully examined. The two important steps in the operation are the reduction of the volvulus of the small bowel and the division of the bands binding the cecum across the duodenum so that it can be placed loosely on the left side of the abdomen. If only one of these procedures is done the condition is but partially relieved. With proper surgery prompt postoperative recovery is to be expected and recurrence of symptoms is unlikely.

Intussusception.—This is the third important gastrointestinal condition that occurs most commonly in infancy. The infant, usually over one year of age and less than five, suddenly doubles up with pain and screams. Then the child usually becomes pale and limp for a short time. These attacks occur every fifteen minutes to one half hour with the child acting fairly normal between attacks. Each spasm telescopes the bowel a little more. The next thing that occurs is the passage of small amounts of mucous and blood by rectum that is squeezed out of the leading "head" of the intussusception. Vomiting is seen only as a late result of the obstruction.

Examination of the child reveals a pale, listless baby who occasionally doubles up with pain. There may be an "empty feel" to the right lower abdomen and the typical sausage shaped mass in the upper abdomen is usually palpable. Rectal examination reveals the "currant jelly", mucosanguinous material in the rectum. Occasionally, if the intussusception has progressed far enough, the end of the bowel can be felt like a patulous cervix by rectal examination.

When the symptoms and examination are atypical a barium enema may be desirable to establish the diagnosis. The column of barium shows the level of large bowel obstruction and outlines the oncoming end of the bowel giving a typical claw-like picture.

There is some contraversy regarding the treatment of this condition. A few advocate attempts at reduction of the intussusception by enema,

Direct surgical reduction is preferrable for severable reasons. Under direct manipulation complete reduction can be assured, even if the intussusception extends into the ileum. Also the condition of the bowel can be evaluated and possible causes for the intussusception can be discovered and treated.

If the case is uncomplicated a small, McBurney's incision usually suffices to allow correction of the condition and necessary exploration. If complications are feared a more generous right paramedian incision is made. The intussusception is reduced mainly by compression of the leading head of the bowel. After the bowel is released warm packs are applied and the viability is evaluated. Fortunately gangrene of the intestine requiring resection and anastomosis is rare. If the ileum alone must be resected the results are good. If large bowel must also be resected the mortality rate increases.

The vast majority of intussusceptions have no apparent cause. We have had only two cases resulting from an inverted Meckel's diverticulum and two from a polyp in the small bowel. Recurrence of intussusception is rare, less than 1% of the cases.

55 E. Washington St.

DISCUSSION

Dr. J. C. Thomas Rogers, Urbana: What is the reduction of the intussusception by barium enema?

Dr. Riker: We have had a reduction when we were doing a diagnostic barium enema but we do not usually attempt it. If the child has had the intussusception for a long period of time or is in shock, we dare not attempt the reduction by the barium enema because we believe that we have to be sure about the completeness of the reduction, about the viability of the bowel, and also about whether there is cause of intussusception that we can correct at the time of surgery.

The Integration of Exfoliative Cytology With General Pathology

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Cytology, the study of cells, may be carried out in a number of ways. The appearance of individual cells makes up an important part of the evidence on which the pathologist's impression is based as he interprets sections of tissue or blood films. Cells which have become detached or exfoliated from an epithelial or serous surface have been the subject of interest long before Papanicolaou[1] began his intensive studies and indeed were among the first objects to be viewed under the microscope. Pathologists at present routinely examine sections or dried smears of the sediment of pleural and peritoneal fluids. The technique developed by Papanicolaou has given pathologists a new means of studying these cells and has introduced new criteria for the recognition of malignant disease. This has permitted the extension of cytologic study to many fluids hitherto not productive of useful information, and to areas of the body hitherto inaccessible except through major surgical procedures. Spreading of the cells on slides, their immediate wet fixation in alcohol and ether, and the light, very transparent staining with hematoxylin, gives striking clarity of nuclear structure, and the cytoplasmic stain affords recognition and differentiation of squamous epithelial types not possible with eosin alone.

The work of many investigators has corroborated Papanicolaou's[2] observation, made over twenty years ago, that cancerous tissue sloughs cells more readily than normal tissue, and that these exfoliated malignant cells can be distinguished from normal cells. We must approach the recognition of these differences by becoming familiar with the appearance of normal cells treated in this way. The squamous and columnar cells of various types and the lining cells of serous cavities display a certain range

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of variation depending upon the layer of epithelium represented and the influences of infection, degeneration, or endocrine changes. The ubiquitous macrophage or histiocyte may assume many confusing forms, and is seen in mitosis more frequently than any other cell type. The nucleus of a benign cell of any type classically displays chromatin which is finely reticular like a translucent cocoon, or finely granular. The malignant cells show striking differences in size and form of cells, size and form of nucleus and nucleolus, and other deformities and changes familiar to the histopathologist. In the nucleus of the malignant cell, chromatin appears in heavy, irregular clumps with clearing of the background substance, a perversion of what is seen in the early prophase of mitosis. The appearance is that of heavy flocculent precipitation of nuclear material. This is not as clearly seen in formalin fixed paraffin sections stained with hematoxylin and eosin and not seen at all in smears dried in air. Smears fixed before drying in alcohol-ether and stained with hematoxylin and eosin show this nuclear structure well if the hematoxylin is light enough, but the hematoxylin used by most pathologists is too dark.

It is not always easy in tissue sections to differentiate between inflammatory or regenerative conditions and malignancy. If there were a clear line of differentiation, a technician could be trained or even a machine devised to read tissue sections. Even with many years of cumulative experience and training to aid them in their judgment, pathologists do not always agree on the most likely future behavior of a given lesion. The cells which in sections of such borderline lesions appear anaplastic, deformed, hyperchromatic and malignant, are seen in cytologic smears also. Their atypia extends through a range of nuclear enlargement and chromatin aberration which merges imperceptibly with the normal and with the malignant appearance. At the latter end of the range there are cases showing abnormal cells which may or may not represent cancer.

In our laboratory, therefore, we report interpretations of cytologic material rather than diagnoses. Five categories, slightly modified from those used by Papanicolaou[3] are employed. Class I reports represent smears in which the epithelial cells are either normal for the area being studied when the age and endocrine state have been taken into account, or show only degenerative changes resulting from infection or trauma. In Class II are recorded smears containing epithelial cells which are believed to be growing or developing in an atypical manner. This group may include examples of hyperplasia, polyp, adenoma or regeneration following injury. Class III comprises the doubtful group in which abnormal, possibly malignant cells are seen. About fifty per cent of these will be proven to represent malignancy. With increasing experience, the pathologist will include fewer and fewer cases in this category. Smears reported as Class IV contain isolated cells or small cell groups which definitely have a malignant appearance. Tissue examination will demonstrate that almost all of these cases have malignant tumors. Class V is reserved for specimens containing tissue fragments which a pathologist will recognize as malignant by the same criteria as in a biopsy. There should be no "false positives" in this group.

The pathologist looking at tissue sections must see abnormal relationships between cells or tissues in order to be certain of the diagnosis of malignancy, because the only facts known about malignant disease which can be applied directly to morphologic examination are those manifested in the behavior of cells in relation to other cells and tissues. We cannot see these relationships in isolated cells so that the evidence from such cells must be considered circumstantial, and only that obtained from tissue sections can constitute proof of malignancy. However, although biopsy is more accurate than exfoliated cells in determining the nature of a given lesion, the epithelial or serous surface area represented by cells in secretions is hundreds of times larger than that represented even by multiple biopsies. Malignant appearing cells often represent a lesion inaccessible to inspection or too small to be recognized by gross examination. Also, we have learned that multiple biopsies may be necessary in order to find early cancer. Skapier[4] reports an interval of from one to three years in three patients with positive cervical smears before the neoplastic areas were located by biopsy, and Kraushaar[5] reports

eleven cases of carcinoma of the cervix in whom initial biopsies were falsely negative.

A review of the literature yields thirteen reported series totalling over 49,000 woman in whom cervical smears were taken as part of routine pelvic examinations. These patients were from hospitals, clinics, and the private offices of internists, gynecologists, and general practitioners. Some had symptoms referable to the genital tract and some did not. Three per cent, or 1,453, malignancies of the uterus were found. Of these, 253, or 17 per cent, were unsuspected clinically, i.e. were not visible or palpable and the history did not demonstrate the need for biopsy. It may be assumed that these 253 women have a much greater expectancy of cure than those with obvious lesions, 70 per cent of whom will be dead in five years according to the reports of Meigs[6] and others.

At Research and Educational Hospitals, smears were taken from 1,600 women seen in the Gynecology Clinic. Seven per cent, or 110, had genital tract cancer, and in 14 of these (12 per cent), the need for biopsy was not indicated by the history or examination, but by the smear report alone. Some of the cases detected by smears are of so-called preinvasive cancer which is not known to develop invariably into true malignancy. In this series eight of the unsuspected cancers were epidermoid carcinoma of the cervix, five of them invasive, and three preinvasive. Seven of the reports from the literature listed the proportion of invasive to preinvasive cancer in 123 carcinomas of the cervix. Fifty-one, or 41 per cent, were invasive, and 72, or 59 per cent, were preinvasive.

In our series, 10 per cent of the patients whose smears were reported as Class IV were found on biopsy to have benign conditions. If positive smears persist, rebiopsy or curettage is done, but sometimes subsequent smears become negative. "False-positive" smears thus mean *only* that patients are subjected to biopsy or possibly curettage. Fifty-eight per cent of the Class III smears were from patients whose biopsies were negative. In some of these, smears become negative, but in some they continue to show abnormal cells. These patients are seen in clinic and smears repeated every three to six months, and are rebiopsied if the smear becomes positive or clinical indications appear. The exact figures for false-negative smears are not available. Smears may fail to detect about as many cancers as are missed by pelvic examination. Most of the cases missed by smears, however, have clinically obvious advanced carcinomas with ulceration, producing only necrotic cells. We know of only one small endometrial carcinoma missed by both types of examination and found in a uterus removed for fibroids.

The usefulness of the method in other areas of the body is not as well documented. Clerf and Herbut[7], studying bronchial secretions, reported cytologic evidence of malignancy in 253 of 285 carcinomas of the lung, while the lesion could be visualized on bronchoscopy in only 78 and positive biopsy was obtained in 99. We have examined sputum or bronchial secretions in 300 patients. Positive smears were obtained in 53 cases proven to have pulmonary carcinoma. Of these, only 32 had lesions visible on bronchoscopy from which biopsy could be obtained. Two positive and 5 suspicious smears were reported in patients believed, on the basis of biopsy and clinical evidence, to have benign conditions.

Urine sediment or prostatic secretion has been examined in 150 patients. The false-negative error is higher than in the female genital or respiratory tracts. Of 60 patients eventually treated for carcinoma of the prostate, smears were positive in only 23. In 13 of these, however, the positive smear was the only microscopic evidence of cancer which the clinicians were able to obtain, and in seven, smears were positive before definite clinical evidence of malignancy was found. Smears were positive in 18 of 23 carcinomas of the bladder. In four cases, however, the lesion was not detected on cystoscopic examination but positive smears led to a second cystoscopy and biopsy which revealed carcinoma. We have obtained positive smears in three of five hypernephromas. Class IV smears were reported in two patients without demonstrable urinary tract malignancy, a false-positive incidence of four per cent.

From a practical standpoint the cytologic method may be fitted into the pathology laboratory without undue difficulty. At Research and Educational Hospitals a technician screens the smears, covering the entire area of the slide in overlapping fields under low power, marking with an ink dot any cells which appear unusual

to her. The pathologist can then look at these slides in no more time than is required for the examination of biopsy sections. Experience with two or three hundred smears of a particular type is necessary before a conscientious and intelligent technician no longer misses positive cells and the slides do not require rescreening. No effort is made to encourage the technician to make interpretive decisions, for *all* slides are read and interpreted by the pathologist. No effort is made to discourage the technician from marking benign cells as it is important that the pathologist see every cell the technician is not sure is normal. Every possible aid in the way of illustrations, reading material, and frequent conferences with the pathologist must be offered the technician. Our four hundred-bed hospital and its clinics involving 170,000 outpatient visits a year, provided about 1,500 cytologic specimens in 1951. This required a full-time technician to prepare and screen the smears and approximately an hour a day on the part of the pathologist.

In summary, the Papanicolaou method of examining exfoliated cells has been shown to be a valuable aid in the detection of occult malignant disease. It is a morphologic interpretive method and properly belongs in the pathologist's laboratory where it can be assimilated and executed under optimum conditions of experience and good judgment.

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Problems and Pitfalls in Cataract Surgery

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In the short period allotted, only brief mention can be made of some of the problems and pitfalls of cataract surgery.

Cataract surgery is attended with more complications than all the other fields of surgery combined, so we owe to our patients every advantage that we can provide in pre-op diagnosis, technique in surgery and postoperative care.

Perhaps the biggest pitfall of all is the decision to do cataract surgery.

An important pitfall is to attempt surgery on a nervous patient. It is generally conceded that the nervous, tense patient has more complications than the relaxed, resigned patient. The surgeon can do much to put these patients more at ease by minimizing the seriousness of the ordeal by assuring the patient of improved techniques, newer instruments, new drugs to fight infections, and that the great majority of cataract patients see very well again.

Failure to do adequate pre-operative examination of general health, type of cataract, status of vitreous whether viscid or fluid, depth of anterior chamber, prescence of synechiae, etc., results in the surgeon following a stereotyped technique instead of a properly planned individual technique.

The surgeon should be versatile and change his plans as each necessity arises.

Beginning the operation on a patient who is tense and excited on the operating table can lead only to trouble, so be sure the patient is more relaxed by giving rectal seconal, then waiting twenty to thirty minutes. Also oxygen per catheter under the drapes helps relieve the feeling that the patient can't breathe.

Most patients under thirty-five are very appre-

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hensive, so I.V. anesthesia may well be considered.

To prevent fear and anxiety about pain, warn the patient immediately prior to injecting the lids, and the retrobulbar and superior rectus areas.

A retrobulbar hemorrhage is attended only with complications, the most serious of which is loss of vitreous. Postpone the operation for at least five to six days. Some surgeons prefer a larger needle than a 26 or 24, and a rather dulled point, to keep from penetrating retro-bulbar vessels. Loss of vitreous is often prevented by using Hydase routinely in the retrobulbar injection — the globe is softer.

Too restricted an operative field taxes the surgeon's nerves and ability. A narrow palpebral aperture and a deep-set globe require a canthotomy. *If in doubt, do one!*

Too energetic pressure on the globe and too hard a grasp with fixation forceps may cause subluxation of the lens. If fixation is difficult due to subconjunctival hemorrhage or conjunctival laceration, fix at the insertion of the inferior rectus muscle 6.5 m.m. from the limbus below.

Lens capsule damage and iris laceration and too much shelving of wound are prevented by remembering that the shallower the anterior chamber, the shorter should the keratome incision be.

The length of the incision is important — it need not be 180 degrees in extracapsular technique and must not be 180 degrees in corneal dystrophy. Otherwise, in a large lens 180 degrees is necessary.

If the patient cannot relax and hold his eye quiet, a preliminary iridectomy is preferred over continuing the operation, and it may suffice for visual purposes.

The occurrence of lens subluxation at the time of incision requires a change in plans. Here loop extraction is preferable, under the Hague lamp — which is indispensable. It is also invaluable in visualizing retained lens cortex and capsule in extracapsular extractions. Repeated attempts to grasp the capsule with forceps may further displace the lens; also viscid vitreous may be grasped with the capsule. Loop extraction is the best procedure.

The method of extraction of a lens dislocated into the vitreous depends on the previously determined condition of the vitreous — if fluid, the surgeon may float the lens to surface with a stream of saline directed into the vitreous. If not fluid, one must use the loop under the Hague lamp. The lens must be visualized and not grasped for blindly. If too difficult to remove, and the patient is quite elderly, leave alone rather than do too much trauma. The patient will have one to two years of good vision before degenerative changes set in.

Good visability of operative field is essential, so if anterior chamber hemorrhage occurs, irrigate. If clots form, it is permissable to grasp them with capsule forceps. Usually patience and a short wait are the best hemostats for anterior chamber hemorrhage.

Vitreous prolapse *previous* to lens removal can be disastrous if extraction is continued as though the accident hadn't occurred. Speculum or lid sutures should be loosened, the superior rectus suture relaxed. If this fails to stop vitreous, a good trick is to do a canthotomy to release pressure on the globe. External counter-pressure will cause expression of more vitreous. It is best to excise the extruded vitreous close to the wound, then attemp loop extraction of the cataract — using capsule forceps to grasp the capsule and assisting with the loop. If vitreous prolapses *after* extraction, tie sutures, and excise extruded vitreous close to wound. Air injected into anterior chamber may help to push vitreous back from the wound and also restore iris position. Any attempt to restore iris pillars by entering anterior chamber with spatula will result in the loss of more vitreous.

Iris sensitivity upon doing the iridectomy may cause the patient to jerk, squint, or complain. This often is a cause of vitreous loss. Before proceeding, insert cocaine drops 5% into the anterior chamber and wait one to two minutes.

Should the capsule rupture early in the extraction, release of external pressure will often cause loss of nucleus, so continue the extraction by continuing the external pressure with the hook and using the lens spoon at the wound. Retained cortex often is less troublesome if cortisone drops are used locally postoperatively.

If anterior chamber is flat immediately upon completion of the operation, it is advisable to inject air into the anterior chamber to restore iris position and allow the intra-ocular pressure

relationship to re-establish. This is especially true if an iridectomy is done. If too much air is injected, release some of it by introducing the iris spatula into the wound.

There are many problems at postoperative dressings. At the first dressing in touchy and uncooperative patients, do not insist on examining the entire wound. This may cause squeezing and do more damage than good. Examine only the lower part — that is the anterior chamber depth, check for anterior chamber hemorrhage, and check for striate keratitis.

Do not use binocular dressings — but use an aluminum shield over the eye pad to protect the eye while the patient sleeps.

Testing of vision at the second or third dressing is a good stunt if the operation proceeded uneventfully. Test with a +10.00 lens — it greatly relieves the patient's anxiety over the success of the operation. If extracapsular procedure was done with or without retained cortex, if there is marked striate keratitis, or if anterior chamber hemorrhage is present it is best not to test vision.

Postoperative disorientation is often a great problem. Sedatives are usually contraindicated. If sitting the patient up in a chair, allowing relatives to remain in the hospital with the patient, and in one-eyed patients if the early correction of operated eye with a temporary lens doesn't help, these patients often recover by sending them home to familiar surroundings.

The problem of a flat chamber postoperatively is best treated by elevating the patient 30-45 degrees in bed so that the anterior chamber begins to form above — it often proceeds to normal depth. In addition, use no pad over the eye, but use a protective shield. If a gross anterior chamber leak is present, of course it must be closed with a suture, or cauterized with Trichloracetic acid.

In expulsive hemorrhage, there is no other choice but to eviscerate at once.

In a choroidal detachment which does not offer a wound leak as the cause, and if it doesn't subside within ten to fourteen days, a scleral trephine must be done at the site of the most extensive choroidal bulging, then air can be injected into the anterior chamber to push the choroid back but care must be used for fear of reopening the wound. This will save many eyes.

Removal of sutures — do with the patient fully quiet, locally anesthetized, and lying down. If doubtful about the patient's cooperation, defer the operation.

The problem of when to use the erisophake is pertinent — never in a subluxated lens extraction for fear of sucking out vitreous. It is best in hypermature lenses. Good also in hard contracted lenses. The chief danger is vitreous loss, sometimes with complete vitreous evacuation. Often the capsule ruptures during the extraction.

The question of intracapsular versus extraction always arises. Generally, an intracapsular is not done in a congenital cataract, in young adults under thirty-five with a strong zonule where the complications are quite serious resulting in a low grade cyclitis, vitreous opacities, etc. It is a poor procedure in patients with head tremors, nystagmus, or traumatic cataracts.

Intracapsular extraction is ideal in complicated cataracts and in patients with senile immature nuclear and cortical cataracts.

Extracapsular extraction is safer in one-eyed patients with a cataract in the only eye, and in those who do heavy work. The vitreous is held well in place and the eye is more stable.

The problem often arises of a patient with good vision in one eye and a cataract in the other. If mature, operate — especially in young women, for cosmetic reasons. The decision to operate depends on the patient's occupation — such as truck drivers who need peripheral vision, etc.

Bilateral surgery should never be done at one sitting. You can do the second eye, if necessary, two or three weeks later.

The problem often arises of cataract surgery in eyes with a filtering bleb above for Glaucoma. Here the best procedure is extracting the cataract through an incision well away from a functioning bleb. Choose either a temporal or inferior route. The iridectomy can be performed as usual.

Traumatic cataract poses many special problems such as the presence of intralenticular or intra-vitreous foreign body, vitreous hemorrhage, retinal detachment, glaucoma, iridocyclitis, endocular infection. In general, if there is a foreign body in the lens with a ruptured capsule,

the cataract should be removed early. The incision is made and the sutures applied as for ordinary extraction. Then with the tooth capsule forceps remove the anterior cortex. Next while the assistant pulls the corneal flap forward apply the giant magnet to the lens area to extract the metallic foreign body. Then proceed with the extracapsular extraction. Waiting may result in synechiae, endophthalmitis, complete cataract with cortex in the anterior chamber, and usually a prolonged period of discomfort, loss of work and mental anguish. Such a patient was referred to me two weeks after such an injury and had developed complete cataract, synechiae, endocular infection with a localized pus pocket behind the iris. Incidentally, chloromycetin is the only antibiotic to enter the vitreous and the only one of value in vitreous infection. The usual dose is 250 milligrams every six hours.

If a cataract is caused by contusion, do not rush to operate — watchful waiting is preferred until the general ocular condition stabilizes, and the status of the retina and vitreous are determined.

In Aparathyroid cataracts, the problem of spontaneous hemorrhage should be considered. Check clotting and bleeding times. Here give calcium and parathormone.

The problem of cataract extraction in glaucomatous eyes is often met with. If the glaucoma is non-congestive in type a combined extraction can be done at one sitting. If the glaucoma is acute congestive, do iridectomy first, then later extract the cataract after all the reaction has subsided. These cataracts usually have weak zonules and are not difficult to extract.

Congenital cataract pitfalls occur mainly in eagerness to operate. Obviously, if the vision is 20/70 or better, it may be hazardous to attempt to improve it — merely direct the patient's life work to proper channels.

If unilateral, it is best left alone — at least until young adulthood.

Do not operate any cataract under one year of age — the cataract doesn't cause amblyopia because enough light enters the eye to stimulate the retina. The number of anesthetic deaths and the poor cooperation of the patient are factors to concern the surgeon.

If nystagmus is present, look for other congenital anomalies in addition to cataract. The ultimate visual prognosis in these cases is poor.

In doing a discission of a congenital cataract do not enter the vitreous with the knife — it is not necessary even if the opacity is in the posterior subcapsular region. The opacities will absorb if the discission is done well. Try not to disturb the vitreous.

Lens extraction for high myopia is dangerous because of myopic degeneration of the retina which results in retinal detachment. Also the vitreous is usually fluid. The surgeon should have other indications in addition to high myopia before lens extraction is done.

Be sure to do a good pre-operative history. Do not operate any patient with Hay Fever in season, arthritis, or sinusitis in humid atmospheric conditions.

Finally, and most important of all, send your best and closest friends to the best eye surgeon you know. If you don't, you will experience all the complications described and a few more!

Rhinoscleroma

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Rhinoscleroma has often been considered a disease limited to people of Central Europe or Central European extraction. However, recent reports have indicated that it is endemic in Mexico and Central America, while occasional sporatic cases have been reported throughout the United States.[1] Three cases of scleroma of the larynx, trachea and bronchi are herein reported in residents of Illinois. From a study of these patients, as well as a review of the literature, the conclusion is reached that the nasal lesion often has laryngeal, tracheal and bronchial complications. Therefore, establishment of the diagnosis of the nasal lesion should be followed by laryngoscopic and bronchoscopic studies to determine the presence of these complications and to initiate early treatment.

History Of Scleroma.—Scleroma is a chronic, infectious, granulomatous disease of the respiratory tract which is thought not to be contagious. It involves both epithelial and mucosal surfaces, frequently to an extent sufficient to cause acute respiratory obstruction. The disease was first described in 1870 by Hebra[2] who named it RHINOSKLEROM, because the primary involvement appeared to be in the nasal passages. In 1882 von Frisch[3] discovered and described a gram-negative bacillus which occurred in both the nasal secretions and involved tissues of patients with this disease. Mayer in 1907[4] reported and published the first case of scleroma with laryngeal involvement in North America. This original article appeared to clarify a number of cases of heretofore undiagnosed granulomatous lesions of the larynx, for in 1908 Friedberg[5] reported a total of 16 "undoubted cases" of rhinoscleroma. Two involved the nose, pharynx, and larynx, and four involved the nose and larynx alone. Many case reports of rhinoscleroma have been published since these early papers, but, with few exceptions, most of these have dealt only with the nasal and pharyngeal manifestations of the disease.

Gerhardt[6] first described laryngeal scleroma in 1876, and at that time it was thought that the disease existed only in Southern Europe. Watkins[7] in 1921 reported the first case of scleroma in this country in a traveled, but native born negro and he described the case as being primarily of the larynx and trachea. Mayer's[4] patient with laryngeal scleroma previously described in 1907 was a Russian immigrant. It is now known that while still not common, the disease may be found in any local and in any nationality. The number of native born cases of scleroma appears to be increasing, (16 out of 102 in the year 1942).[9]

In this discussion the laryngeal, tracheal and bronchial aspects of the disease will be stressed as they appear from an endoscopic standpoint.

Report of Cases.—Three cases, all foreign born males, are reported. Two cases had laryngeal and tracheal involvement alone; the other showed nasal as well as lower respiratory tract manifestations. All varied in their degree of granulomatous extent.

Case 1. E. C., was a 35 year old Italian laborer who had been in this country 28 years and had been a resident of Illinois for 15 years. He had been hoarse for fifteen years and had had a cough for two years, but otherwise no noticeable difficulty in breathing was apparent until two days before his death. He choked suddenly while working and died on the way to the hospital. Postmortem examination by Dr. Edwin Hirsch showed marked mucosal thickening from the level of the laryngeal aditus, to and including the true cords. There were marked swellings approximating one another in the laryngeal vestibule and these almost completely closed the lumen of the larynx. Histologic examination of these indurated areas showed the typical Mickulicz cells characteristic of rhinoscleroma.

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Case 2. A. G., age 28, was born in Poland. In 1943, while in the Russian Army, he became hoarse and later required a tracheotomy which he maintained from 1943 to 1947. The tube was then removed after extensive endoscopic resection of tissue from the larynx. He was a resident of Illinois from 1947 to 1949 at which time he was under the care of Dr. Heinrich Kobrak at the University of Chicago. Bacteriologic studies there demonstrated K. rhinoscleroma. Biopsy of tissue removed endoscopically from the larynx demonstrated the foam cells and other histologic characteristics of this disease, although sections were considerably distorted by nonspecific secondary infection. His recent symptoms which required re-examination in this country have been alleviated completely by streptomycin therapy.

Case 3. J. S., a 41 year old Mexican male, was brought in early childhood to Illinois where he has resided continuously until the present time. He had been dyspneic for approximately four years and had had a coexisting rhinorrhea. Relief of the symptoms followed removal of multiple tumors of the nose, and endoscopic resection of tissue from the larynx by Dr. George Carlin of Joliet. Histologic examination of this tissue revealed the characteristic cellular structure of rhinoscleroma. At the time of our examination at St. Luke's hosiptal, there was a recurrence of the granulomas in the nose, and extensive crusting in the nose and pharynx. A direct examination of the larynx demonstrated the motility of the cords to be normal. The epiglottis was somewhat deformed and rigid, and examination was somewhat obscured. Immediately below the larynx a marked obstruction was found due to an extensive web and an area of ulceration which left only a small lumen posteriorly. Lateral x-rays of the neck confirmed the presence of tracheal obstruction. Therapy consisted of one gram of dihydrostreptomycin daily for three weeks. He has gained 40 pounds in weight and has no further respiratory difficulty.

DISCUSSION

Rhinoscleroma occurs with equal frequency in males and females. No age group is exempt, but greatest incidence occurs between the fifteenth and thirty-fifth year. Poor hygiene appears to be a contributing factor for the greatest number of patients seem to come from a background of uncleanliness or poor sanitation.[7,10]

A review of the basic pathology of scleroma permits a better understanding of the mechanics of respiratory changes caused by the disease. The gross appearance of the lesions seen endoscopically is usually described as a diffuse, indurated, infiltrating granuloma causing submucosal thickening and consequent stenosis of the airways. Szmulo[11] classified the lesions as a discreet nodular type and a diffuse infiltrative type. He described three stages of their development: first, a diffuse stage with early infiltration of the submucosa and atrophic changes in the mucosa; second, a discreet nodular infiltration of the submucosa with gradual confluence of the nodules into one large, granulomatous mass. It is in this stage that the elevation of the mucosa may be so marked that the air passages are encroached upon. The third stage is a fibrosis of the submucosal diseased areas and a resulting gradual, concentric stenosis. In all of these changes the mucosa is usually seen to be intact and smooth, although it frequently appears to be injected and indurated.

The microscopic picture is described almost uniformly by all authors: there is a papillary hyperplasia and hypertrophy of all involved epithelium and mucosa. Beneath this, the propria layer is infiltrated with plasma cells and large foam or Mikulicz cells. The bacilli of Frisch are found in vacuoles in these cells. Russell bodies are a second type of characteristic cell seen in scleroma. They are felt to be plasma cells with excentrically placed nuclei and eosin staining cytoplasm.

The diagnosis is established by means of tissue biopsies,[10] although some authors feel that a positive culture of Klebsiella is diagnostic.[13] Smears have been used or this latter purpose. Those who adhere to this latter concept have had bacteriologic reassurance with improvement of these lesions under streptomycin therapy. Levine[14] has described a complement fixation test that has been used successfully.

Although it would appear that streptomycin is now specific for K. rhinoscleromatis[15,16,17] rather than the formerly used x-ray, radium or fulguration, there remains a definite place for endoscopy in the management of this disease. As demonstrated by two of the three cases herein reported, a tracheotomy was necessary for sudden episodes of dyspnea, although in one of the two

cases, death occurred before the patient reached the hospital. With endolaryngeal and endotracheal resection of the scleromatous tissue, one of these patients regained the use of his natural airway. With subsequent laryngeal web formation, repeated dilatations were necessary.

These findings make it apparent that all cases of nasal rhinoscleroma should be further investigated endoscopically.[12,5] Because of its granulomatous nature, tuberculosis, syphillis, fungus infections and carcinoma should always be ruled out in these lesions.

SUMMARY

1. Rhinoscleroma is a chronic, infectious, granulomatous disease that may occur at any level of the respiratory tract.
2. Laryngeal, tracheal and bronchial involvement of rhinoscleroma may exist without any nasal counterparts.
3. Although in the past the disease was associated with Central and Southern Europeans, it is now seen with increasing frequency in this country. Three cases in Illinois residents are reported.
4. Because of possible sudden death in patients with rhinoscleroma due to respiratory obstruction, it is suggested that all cases of nasal rhinoscleroma be examined by laryngoscopy and bronchoscopy.
5. Endoscopic removal of tissues obstructing the airway is an important adjunct to streptomycin in the treatment of rhinoscleroma.

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"AMERICA"

Oh, land of vast and fertile fields
Two oceans lap your shores
A hungry world depends upon
The crops your harvest yields.

Your mountains so majestic,
Their summits capped with snow
Are challenged by your cities
With giants all aglow.

Your rivers flow down to the sea
And on their bosom carry
Great wealth of man-made luxury
A world essential ferry.

Your peoples came from everywhere
To fuse a mighty nation,
And hand in hand a freedom share
The noblest in creation.

And yet 'Collosus' in your might
Twice have you thrown your weight
Into the scale of Peace and Right
And saved the world from Fate.

May God in all His Greatness
Wherever He holds court
Keep His arms around your shoulders
And yield you His support.

America, America, stay virile
young and strong
Let history immortalize, your
Courage and your song.

Robert Sixtus Berghoff, M.D.
Member Board of Education
City of Chicago

Cold Injuries

David I. Abramson, M.D., Clinical Assistant Professor of Medicine, N. O. Calloway, M.D., Clinical Assistant Professor of Medicine, Peter J. Farago, M.D., Clinical Instructor in Medicine and Robert M. Kark, M.D., Professor of Medicine.
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Dr. Max Samter: The Korean War has emphasized the importance of cold injuries in military medicine and, by implication, in medicine in general. Dr. Calloway, who has returned to us after two years of service with the U. S. Army, has invited a panel of experts who are familiar with the basic physiology and the practical management of this syndrome.

Dr. N. O. Calloway: Dr. Samter says "experts" — a term which must be taken advisedly. What I, for instance, know of cold injuries I learned almost out of self-defense — by being assigned to an installation where I had to take care of seven or eight hundred cases. Our use of the word "cold" would make a physicist shiver. What we mean is "loss of heat from the body which causes either a general response or a response of the tissues exposed to it". Dr. Kark has done considerable work on the adaptation of men to cold — particularly, on the efficiency of man at low temperatures.

Dr. Robert M. Kark: I think you might be interested to hear what I think is the first description of cold injury. The passage I am going to read is from Xenophon's "Persian Expedition". In the beginning of the fourth century B.C. a Greek force invaded Persia and after the battle of Cunaxa were escaping from the Persians. Ten thousand Greek soldiers had to march to the Black Sea, and in this march they were constantly harried by the Persians and bitter weather as they went through the high mountains of Armenia. This is what Xenophon wrote:

"Next came a three days' march of forty-five miles over level ground and through deep snow. The third day's march was a hard one, with a north wind blowing into their faces, cutting into absolutely everything like a knife and freezing people stiff. . . . The snow was six feet deep and many of the animals and the slaves perished in it, as did about thirty of the soldiers. . . . The whole of the next day's march from here was through the snow, and a number of soldiers suffered from bulimia. Xenophon, who, as he commanded the rearguard, came upon men who had collapsed, did not know what the disease was. However, someone who had had experience of it told him that it was a clear case of bulimia, and that if they had something to eat they would be able to stand up. So he went through the baggage train and distributed to the sufferers any edibles that he could find there, and also sent round those who were able to run with more supplies to them. As soon as they had had something to eat they stood up and went on marching."

This disease, bulimia, is certainly a collapse in the cold from general loss of body heat and from slowing down of heat production due to severe caloric deficiency. Here is a list of diseases which are caused directly by cold:

Chilblains (Pernio)
Local Frost Bite
Severe Frost Bite
Frozen Lungs
Hypothermia (Bulimia)
Immersion Foot
Cold Urticaria
Cold Hypersensitivity (with or without collapse)

It is fairly obvious that we will never be able

to cover them today. Now, if I could have the slides run through, I can rapidly show you the ones that we will probably talk about today.

Slides: The mildest injury is chilblains (Pernio). Chilblains are very common in some parts of Europe, in South Australia, England and in South Africa, where the outside and inside temperatures go down to 30° to 50° F. In these areas there is no decent central heating, and fingers and toes are cold.

This next slide shows you something about the effect of geography on climate. Here in the northeast of Canada in the Barren Lands you get a dry cold with high wind velocity and severe "wind-chill", causing great body heat loss, which produces bulimia and frost bite. Towards the northwest and in Alaska you have a forest region where the temperature goes lower than the east, down to −60° F. and sometimes −75° F. but no wind. In this part of the continent if you run and rapidly inhale very cold air you may freeze or "burn" your lungs. Here in Newfoundland and in the Aleutians you have a high wind velocity, and a wet-cold with a great deal of sleet but without very low temperatures. This produces frost bite but more commonly immersion foot. In the sea you have temperatures which go down to 34° F. to 46° F. Death from heat loss in northern seas can occur within twenty minutes. After shipwreck, people in lifeboats are prone to immersion foot, as are soldiers in fox holes in wet-cold areas.

Our studies in World War II were made in all these areas by a mixed United States and Canadian Research Unit. Most of the men we observed were acclimatized to cold weather, but the next slide outlines a study of 32 Army volunteers who lived in Florida, who had never been out of the south, and who were flown overnight from a temperature of 70° F. to Canada where it was −40° F. There they were left in the snow to study survival after a simulated aircrash in the Arctic.

This next slide shows that to survive in the cold you must have proper clothing; you have to be able to get a source of water; you have to have fuel to melt ice or snow for water; and you have to indoctrinate men in technics of living in the cold. You will freeze if you do not know how to look after clothes, gloves, socks, boots and sleeping bags.

Here is the type of territory that you see in Alaska and in the Bushland of Canada, with scrub pine and large areas of frozen lakes which men can go across walking or pulling toboggans.

This next slide shows a case of bulimia in a soldier. From the studies that many people have made, there are certain generalizations one can make and some of them, I am sure, you are familiar with. This slide shows that the colder the weather, the more you eat. When you get down to −20° F. or −30° F. men easily consume 5,000 or 6,000 calories a day. Besides this increase in calories, there is no change in their metabolic mixture with regard to carbohydrates, proteins, fat, so that in all climates soldiers usually eat between 11% to 13% protein, 35% to 40% fat, and the remainder as carbohydrates.

Now we come to a certain generalization about cold. What are the effects of cold on man? You have to think about cold temperatures in two ways: first, cold weather (i.e. short-term effects) and second, cold climate (long-term effects). We all have reacted to the effects of cold weather and the most common thing that happens to you is a cold diuresis. Cold diuresis is the result of movement of body water away from external tissues towards the central body core, and instead of increasing the blood volume, the water pours out in our urine. There are some studies which show very clearly a movement of water to the liver and other organs since it has been shown by x-rays that as you take a person and put him in a cold room, the liver enlarges. . . . These changes are associated with a vasoconstriction all over the body surface, and the effects of weather on man were clearly shown by Johnson and his group in the study at Camp Shilo. A cold diuresis is not something that happens once and then stops, but it is repeated whenever the weather changes. At Shilo when we plotted environmental temperature against hematocrit, we see that whenever the temperature went down, the hematocrit went up. This is not an effect of climate but of the weather. These are short-term adaptations, but acclimatization is always a long-term thing. As far as animals are concerned, acclimatization to cold is associated with changes in the adrenal glands, in the thyroid gland and in other metabolic and physiological mechanisms which occur over a long period of time.

As far as I know, the evidence of acclimatization to cold in man is extremely tenuous. The people who are best acclimatized are the Patagonian savages and the people who live in Belgium, England and Holland, where the temperatures are down about 30° F. to 50° F. and the people do not have central heating in houses and often do not have the adequate clothing. There has been a general feeling that there is no true acclimatization to cold as there is for heat. There are, however, a few things which indicate an acclimatization to cold in man. First of all, some Norwegians have shown that the body surface fat has different melting points in summer than in winter. Secondly, we found an increase in protein-bound iodine levels after prolonged exposure to cold. Third, we found that when troops first arrive in the arctic they eat ravenously. Everybody gains weight. After they gain a certain amount of weight, they level off. That seems to be an adaptive mechanism which lays down 15 pounds of fat upon the body surface, perhaps to increase "insulation".

Dr. Ford K. Hick, Professor of Medicine: Can you tell us how wind chill is measured?

Dr. Kark: The cutaneous sensation of cold depends upon the rate of cooling of the skin. This in turn is proportional to ambient temperature, wind velocity, and area of exposed skin surface. Winter clothing serves, of course, to minimize the area of exposed skin surface and to mitigate the effects of temperature and wind. Outdoor weather conditions as they affect the rate of cooling or of heat loss are, therefore, more properly considered, not in terms of temperature alone, but in terms of both temperature and wind velocity. One function of these latter two variables is called "wind-chill". This is a non-linear relationship of the rate of atmospheric cooling to wind velocity and temperature and is based upon measurements on a body at a neutral human skin temperature of 91.4° F. (33° C.) when the body is dry (non-sweating), shaded, and in a state of inactivity. Units of wind-chill are usually expressed as Kilogram-Calories per square meter per hour; at wind-chills greater than 1400, exposed flesh will freeze.

Dr. Calloway: Until the fall of 1950, the date of the big withdrawal along the Korean border, frostbite was not a problem for the American army. At that time the armies were moving rapidly in Korea and in the upset of tactical situations there was a great deal of exposure. One must ask how this exposure occurred; couldn't it have been anticipated and prevented? We have several answers. Supplies brought up as rapidly as possible were often delayed — food and clothing. The warfare itself became so personal that it was difficult for the men to care for their feet. If they were able to change their socks, and keep their feet dry, frostbite could be largely prevented. The personal aspect of the fighting was most impressive. There was literally a Chinese behind every bush. The Chinese would grab their shoes. They wore sneakers in combat; but, incidentally, were not better adapted to cold than our soldiers: they had a tremendous amount of frostbite. Wounded soldiers presented added problems. If a man received a thigh wound, the blood would trickle down his leg and the blood would freeze in his shoe. Other tactical problems that produced frostbite were the irregularities of the country side. One man would get into a fox hole on the side of a hill. He should withdraw, but there was no way to withdraw. He was pinned down by gunfire. The temperatures dropped very rapidly to around −25° F., and it was at this temperature that cold injuries were sustained. We did not see much trench foot, that is, long exposure at relatively high temperatures. Our injuries resulted from rapid freezing.

One might say that chilblain results from one type of exposure, namely, long exposure at temperatures as high as 50° F. Trench foot resulted from moist exposure at about 30° F. It was common in World War II during and following the Battle of the Bulge. Besides the Korean type of cold injury — rapid freezing at low temperatures — there is a third type of what has been called the "quick freeze", just as if you would prepare fish: this is seen in high altitude flying. At such altitudes exposure caused by even a small piece of flack will freeze the men during the time they need to get their clothes on.

Our own special interest concerns the foot soldier. First, 85% of our patients were returned to duty. Of 5,000 cases of frostbite which had to be removed from combat, approximately 700 were brought back to the U. S.; 4,300 went back to duty from Japan. Of the number that came back to this country (most of whom were at the Percy Jones Hospital), about 80% went

back to duty, so that the total number that remained disabled was very small. Our standard treatment was known as the "frostbite solution". It consisted of the intravenous injection of a mixture of 12 cc. ethyl-alcohol and 250 mg. procaine hydrochloride in 250 cc. normal saline. If the individual was not bleeding and had no obvious wounds, we added 50 mg. of heparin. It is given every six hours with 600,000 units of penicillin. The incidence of osteomyelitis was almost zero. Not a single case of tetanus occurred in our patients. The Chinese, by the way, had 10% of tetanus, so that apparently it was the prophylactic program which protected our men. All patients who showed even a slight blister were made litter patients. One of our big previous errors was to demand that the boys walk back to the next aid station. Those who walked were the ones that got into difficulties.

The length of time required for healing is often unexpectedly long. In one or two cases, on the other hand, cold injuries healed much more rapidly than we had anticipated. We found that there was no way to predict the length of the convalesence by the inspection of the frostbite. Some sort of correlation exists between the temperature, the duration of the exposure, and the duration of the injury. Two individuals suffering from frostbite may have injuries which look alike, yet one will stay 16 months in the hospital; the other, three weeks. At a practice maneuver in the winter of 1951 the boys were dropped in their chutes at 800 feet. They went into the snow banks. There were some trucks that were supposed to pick them up. The trucks were delayed, and the soldiers waited in the snow for three hours. Several of them received 2nd and 3rd degree frostbite. Every one of them was back on duty in less than a month.

We now divide frostbite, for practical purposes, into four degrees of progression:

1. erythema,
2. blister,
3. loss of tissue, and
4. necrosis

Dr. David I. Abramson: It is interesting that the cases of cold injury seen in World War II appear to be so different from those arising from the Korean War. As Dr. Calloway mentioned, the former group developed trench foot as a result of exposure to only moderate cold, combined with prolonged dampness and muscular inactivity. The soldiers under enemy fire were unable to remove wet socks and foot gear for days on end. Regardless of what precautions they took, their feet were continuously wet. The changes produced by such exposure can be divided into the following stages:

(1) *Prehyperemic stage*: During the period of exposure the soldier first noticed an uncomfortable sensation of coldness of the feet, followed by numbness and aching and then tingling or cramping pain in the arches and soles of the feet. Aside from having some difficulty in walking, described as "walking on blocks of wood", the patient experienced little discomfort during this period. Swelling was noted when the shoes were removed. Initially, the foot was red and then became waxy white, or it demonstrated mottled cyanosis. Hypesthesia or anesthesia existed in some instances. In cases of prolonged exposure, areas of incipient or actual gangrene were present, especially around the toes. Pulsations in large vessels were reduced because of the presence of vasospasm. This prehyperemic or ischemic stage lasted for several hours.

(2) *Hyperemic stage*: The next phase in the clinical picture was the hyperemic or inflammatory stage. This was not always observed, but when present it would last from a few days to several weeks. In it the swelling increased rapidly, at times extending as high as the knee, and the feet became red, hot and dry. The pulses were now full and pounding. At this time trophic changes appeared. Blebs, filled with straw-colored fluid or extravasated blood, were almost invariably noted except in the mild cases. Intense burning pain replaced the early hypesthesia or anesthesia. This symptom was relieved by cold and aggravated by heat and dependency. Other complaints indicating injury of nerves, such as tingling, hyperesthesia and paresthesia, were also experienced. Gradually all these symptoms disappeared, the rubor slowly fading to a waxy pallor or a normal color and the swelling decreasing.

(3) *Post-hyperemic stage*: In this phase of the disorder the foot became cold, blue and sweaty, as a result of increased sympathetic tonus. There was recurrence of pain, tingling and swelling, especially on walking or prolonged

standing. Rigidity and atrophy of the foot generally occurred, due partly to disuse. Hyperhidrosis of varying degree was a fairly common finding, as well as marked sensitivity of the sole of foot to pressure.

(4) *Stage of Sequelae*: The sequelae were divided into three categories. In one the predominant findings were those of excessive sympathetic activity, as manifested by a low cutaneous temperature, cyanosis, hyperhidrosis, a subjective sense of coldness, swelling on prolonged standing and marked responsiveness to extremes of environmental temperature. The pulsations and oscillometric readings were found to be normal in the lower extremities. In the second group the symptoms were primarily those due to peripheral nerve involvement and consisted of numbness, paresthesias, burning, shooting pains and tenderness, particularly over the sole of the foot. Most of the patients fell into the third group in which the symptoms were both circulatory and neuritic in origin.

When the patients entered our Vascular Center, approximately two or three months after the onset of the condition, our main aim was to rehabilitate those who did not have actual destruction of tissue. Since they complained bitterly about placing the weight of the body on their feet, we attempted to counteract this by having them walk in a pool filled with lukewarm water. In that way the buoyancy of the water helped to reduce the pressure on the feet. We also used a shoe with two heels, one placed in front of the ordinary heel. As the patients continued to walk using this type of shoe, the second heel gradually wore down, allowing some of the pressure to be applied to the sole of the foot.

I have been seeing a number of those patients at the Regional Office of the V. A., and despite the fact that eight or more years have passed since the acute phase of trench foot, many of them still complain of the symptoms which I have enumerated. They state that they experience various types of paresthesias in the feet and that there is a subjective sense of coldness present. They are markedly responsive to extremes of environmental temperature. In most instances objective findings are minimal. There may be some minor neurological abnormalitics and signs of vasospasm. How much of their clinical story is colored by the fact that they are rcceiving a pension from the government is difficult to say. In fact, I am treating patients who acquired trench foot in World War I, and they, too, are still complaining of difficulties.

With regard to the prevention of trench foot, there is nothing at present which is effective under all circumstances. The various types of boots that have been devised have the disadvantage in common that they prevent evaporation of moisture from the feet. If this is allowed to condense while the patient is inactive, the socks will become wet. Such a situation will be just as effective in producing trench foot as getting the feet wet because of exposure to dampness and mud. It would appear that the only certain way to prevent trench foot is to do away with war.

Dr. Peter J. Farago: Dr. Calloway has asked me to discuss certain of the clinical aspects of frostbite. Much of this has already been covered, and I will therefore make my comments brief.

One of the first things we did was to study the effectiveness of various vasodilators. Procaine, whiskey, hexamethonium, priscoline (orally and parenterally), and nicotinic acid were tried. These studies were done in a constant temperature room. Skin temperatures were utilized. Hexamethonium proved to be the most effective vasodilator and produced approximately a 20 degree rise in skin temperatures which was maintained for 6-7 hours.

We then took approximately 30 patients who had third-degree injuries and used 10 as a control group. The remaining 20 were divided into 2 groups. One of these latter groups received 20 mgm. of hexamethonium (IM) daily, while the other received 40 mgm. of hexamethonium (IM) daily. There were no significant side reactions to the hexamethonium. (It is to be remembered that our patients were in the young age group.) The results as to the therapeutic effectiveness is a difficult one to evaluate since so much depends on how each physician interprets the progress of the lesion. It is not possible to measure skin temperature over gangrenous parts. Effect of therapy is purely a clinical evaluation. We did not feel that the vasodilators were of any therapeutic value at this stage.

Studies on ACTH and cortisone as therapeutic agents were carried out in much the same manner. It was felt that by lessening collagenous

tissue changes some benefit might be obtained or that healing might be accelerated as in burn cases. It is too early to say whether or not the sequelae of painful feet has been accomplished. However, all these drugs seemed to do was to produce a mild euphoria and a decrease in some of the purulent drainage. They did not make any significant difference in the final outcome.

How, then, are you going to treat frostbite? I think the important things are to, at all times, avoid any type of vaseline pressure dressing. If you get patients soon after their frostbite injury, then vasodilators and anti-coagulants may be of value. Rapid warning seems to be indicated, although this is a subject of much controversy. Early bivalving of gangrenous eschars to prevent constructive damage is exceedingly valuable in salvaging tissue. Conservative therapy for one to two months in the hospital is indicated and then a great deal of recuperative treatment can be done at home. All of our patients in the Army had received 300,000 units of penicillin daily and a booster dose of tetanus toxoid. It is interesting to note that we did not have a single case of tetanus, and our incidence of osteomyelitis was practically zero.

There are many interesting aspects to this disease, e.g. a high percentage of people with frostbite have a positive cold agglutinin test.

However, at present the point to be stressed is that the treatment of frostbite is prevention and this treatment is rendered most effectively by personnel in the field of battle action.

Dr. Calloway: We are learning very slowly. There was much resistance, for instance, to rapid thawing of frostbite at 42° F., which is now the method of choice. Thawing causes a hyperemia at the margin of the freeze. Many of us objected to that, but it has been shown that the rapid thawing made it possible for the most tissue to be saved.

Dr. Kark: Dr. Adams-Ray of Stockholm froze two spots on each of two legs that he was going amputate. One side was then warmed rapidly and on the other the frozen areas were thawed slowly. The two areas of the frostbite were biopsided. He found that rapid thawing was far superior in protecting tissue.

Dr. Carroll F. Birch, Professor of Medicine: You say that down at Fort Knox a large percentage of soldiers had cold agglutinins.

Dr. Calloway: About 40% had cold agglutinins.

Dr. Birch: If these cold agglutinins were present before the injury why could not this group of soldiers be sent to the tropics?

Dr. Calloway: They tried to predict the men who would be susceptible to cold, an attempt which proved to be quite impossible. In Korea and in the Battle of the Bulge the experiences were about the same. Cold agglutinins were only one factor. On the other hand, soldiers who had symptoms of psychoneurosis or autonomic disorders of less well defined origin, such as sweating in the palms of the hands, formed a large percentage of frostbite cases.

Dr. Kark: I can't accept the idea that neurotics get frostbite. The best controlled epidemicological study on the etiology of frostbite was made last year in Korea by Colonel Schumann and Colonel Orr. At that time the line in Korea was fixed. The only cases of frosbite occurred in men on patrol. For example, if eight men went out on patrol, perhaps two of the eight did get frostbite and the other six would be all right. They, therefore, had a very good control group to study and could study all the factors bearing on the development of frostbite in soldiers. Under these conditions they showed very clearly that frostbite is a preventable disease and they believe that the responsibility for prevention of frostbite should be made a command responsibility rather than a medical responsibility. Their data clearly show that the people who got frostbite were not neurotics but individuals whose educational background was poor or whose intelligence was low. Apparently the difficulty is that these men cannot be indoctrinated to carry out proper preventive measures against frostbite while they are in the front line. (See: Josiah Macy Jr. Annual Symposium. "Cold Injury" for all up-to-date studies on effects of cold on man and animals.)

Dr. Walter Wood, Resident in Medicine: Why don't the Eskimos get frostbite? I wonder whether they have better protective foot gear than the U. S. Army?

Dr. Kark: That depends on fur supplies. You cannot get wolverine fur. You cannot bring a caribou skin to a temperate climate without it rotting.

Dr. Calloway: I think that you again must realize that the soldier is not living under the conditions of the Eskimo. The stress of the battle is undoubtedly a major factor in the etiology of frostbite. Some of us thought there is correlation between the nutritional status at the time of exposure and the incidence of frostbite. Many of the soldiers were separated from their sources of food for several days. The physicist, Sheard, thought that food was probably the best vasodilator substance that can be taken.

Dr. Harry F. Dowling, Professor of Medicine: What do you think of the vasodilators, Dr. Abramson?

Dr. Abramson: Food, I believe, causes very little dilatation of the blood vessels. Vasodilators are for the most part ineffective.

Dr. Calloway: We have a chart which might summarize one or more of the answers to the question of the effectiveness of various drugs on cold injuries. Procaine had some effect. Nitroglycerin ointment was ineffective; in fact, it caused infections by sealing moisture into the area of the injury. Whiskey seemed to get results. It was given in doses of two ounces every six hours; since most of our patients were just out of high school, two ounces of whiskey had produced a rather unpredictable behavior. Intramuscular priscoline was fairly effective but, interestingly enough, not so effective as oral priscoline. Of all the drugs, Hexamethonium appeared to be the most reliable compound and also finally the only drug that we kept using.

We have amongst our guests three representatives of the U. S. Army who might like to comment on some of the questions.

Lt. Col. Carl Kochn, Medical Service Corps, U. S. Army: One of the questions which was brought up concerned the Eskimos who do not seem to suffer much from frostbite. The reason is probably that they remain in the igloo as soon as the temperature goes down.

Dr. Harry Spector, Chief, Nutrition Division, QM Food & Container Institute for the Armed Forces: The Medical Nutrition Laboratory, SGO has undertaken a study of a possible effect of liberal amounts of vitamins on the performance of soldiers in a cold environment. Unfortunately, after selecting a place which is supposed to be one of the coldest places in the United States, they ran into the finest winter in years. Although the results are tentative, gross evaluation indicates that vitamins have no beneficial effects. Due to the excellent Arctic clothing the soldiers were protected and comfortable in all kinds of weather which they encountered.

Dr. Doris Calloway, QM Food & Container Institute: It is interesting that the soldiers continued to improve in physical performance even though they were placed under conditions of rather rigorous physical activity, e.g., forced marches, with calorie expenditures of 4,000 and intakes of 2,500 during part of the test. Vitamins were given but made no apparent difference. In fact, there was no difference of any kind except when they were exposed to cold without adequate clothing, where some variation in rectal temperature was observed.

A Physician: What were the housing conditions of the troops during the test?

Col. Kochn: They were quartered in barracks heated by pot-bellied stoves. It was ruled that the stoves had to be turned off before the troops went to sleep. They did complain about being cold during the night. I might add one remark about our new boots: we now have insulated rubber boots which are quite comfortable and keep one's feet warm if one moves around reasonably.

Organic Phosphate Poisoning

Walter K. Grigg, M.D.
Senior Assistant Surgeon, U. S. Public Health Service
On Loan To State Of Illinois, Acting Health Officer,
Lee County.

Physicians in rural areas should be alert for signs or symptoms suggestive of poisoning through the use of a new type of insecticide, the organic phosphates. These compounds are the much discussed "nerve gases" developed by the Germans during World War 2, but never used as a war gas. Subsequent investigations have proved their great value as an insecticide. The organic phosphates are very effective against many insects. They will be widely used by farmers this year despite their lethal qualities to humans.

In 1949 with only moderate use of these compounds three deaths were reported. Investigation proved that every fatality was caused by improper handling of the insecticide.

The three most important of the organic phosphates are discussed below.

(1) HETP (*hexa*-ethyl *tetra*phosphate)

(2) TEPP (*tetra*-ethyl *pyro phosphate*)

Both HETP and TEPP are mixtures of esters, the principal active agent of which is tetra-ethyl pyrophosphate. The commercial preparations are straw colored fluids that are stable at room temperature, but decompose at higher temperatures liberating ethylene gas. They are hygroscopic and miscible with water. They are hydrolyzed very quickly and the hydrolysis products are non toxic. These properties are very important since both compounds are rapidly detoxified by the body and chronic poisoning through storage of the compound in the tissues is not possible. They are used only as contact poisons.

(3) Parathion (O',O diethyl o-p-nitrophenyl thio phosphate) is an ester of thio phosphoric acid and is a light brown color with a characteristic onion odor. It is soluble with many organic solvents, but is only slightly soluble in water.

It is decomposed by alkaline substances such as lime, lime sulfur, etc., but is not hydrolyzed as are TEPP and HETP. Parathion is slightly volatile. It may be used as a fumigant, contact or stomach poison. When sprayed the residual lasts 1-3 week before completely vaporizing.

Each of the organic phosphates is available commercially under numerous trade names. Some of these are:

HETP and TEPP-Sold as Agrifume, Bladex, Fosvex, Hexate, Hexalone, Hexidust Killex, Niagra hexide 200, Nifos-L, Phosphofume, Phosphos Tetra-chem, Tetracide, Tetratone, Tetron, and Vapatone.

Parathion-Sold as Alkron, Aphamite, Durathion, Genithion, Niran, Par, Para-dust, Parakill, Paraphos, Phenphos Phoskil, Planthion, Thiondust, Thioplos, and Vapothos.

The mode of action in each of these compounds, however is the same that is through inhibition of cholinesterase. The physiologic effects and treatment are therefore also the same for each. In the human the inhibition of cholinesterase causes excessive stimulation of the parasympathetic nervous system, the central nervous system and the somatic motor nerves.

Treatment is an emergency procedure since signs and symptoms occur in about five minutes, and death may occur within two hours. There is only a narrow margin between a dose that will cause death, and the dose that will only cause symptoms. Repeated exposure to HETP, TEPP, or Parathion will deplete cholinesterase and then exposure to a very small amount of any organic phosphate insecticide may cause extremely severe signs and symptoms.

Signs and Symptoms	Early	Late
Central Nervous System	Giddiness, uneasiness, restlessness, anxiety *headache.*	Tremor, ataxia, drowsiness, mental confusion, disorientation, excessive dreaming, *Coma* generalized convulsions.
Eyes:	Blurred vision and slight constriction of pupil	Miosis-Pinpoint non-reactive pupils
Circulatory	Pulse slowed	Elevation of blood pressure, A-V-Block, cardiac arrest-(Vagal)

Respiratory system:*	Increased respiratory rate - shallow respiration. Excessive secretions	Weakness of respiratory muscles; pulmonary edema, Chayne - Stokes breathing, respiratory failure (cessation of breathing)
Gastro-intestinal*	Anorexia, nausea	Vomiting, abdominal cramps, tenesmus, diarrhea, involuntary defecation.
Musculature	Muscle fasciculations of tongue and eyelid	Fasciculations of muscles of face, neck, arms and legs. Weakness of respiratory musculature.
Glandular	Hyperhidrosis, lacrimation salivation	

*Most severe when this system is route of exposure

Treatment

1. Atropine Sulfate 1-2mgm
 i.v. or i.m. for first dose-thereafter repeat i.m. as necessary to keep patient completely atropinized. Usually hourly dosage necessary.
2. Prevent further poisoning
 (a.) Remove patient from site of vapors.
 (b.) Remove clothes if contaminated.
 (c.) If contact poisoning-wash thoroughly with soap and water or lime solution.
 (d.) If poison is ingested-aspirate stomach contents and lavage.
3. Hospitalize and keep under close observation.
4. Treat respiratory disability, if present.
 (a.) Use postural draining or clear airway by suction.
 (b.) Positive pressure oxygen.
 (c.) Artificial respiration may be necessary since atropine does not help the muscular weakness that is present in cases of severe poisoning.
5. Do *not* use morphine.
6. After recovery from the acute attack-do not permit patient to return to work using any organic phosphate until laboratory tests indicate the blood level of cholinesterase has returned to normal.

Laboratory Tests:

The Illinois State Health Department laboratory, Chicago branch, is prepared to perform the Cholinesterase test. Specimens must be submitted in special containers (containing a measured quantity of Heparin) The containers are obtained from:

Division of Laboratories,
Howard J. Shaughnessy, P.H.D.
1800 W. Fillmore,
Chicago, Illinois
Phone Taylor 9-3100

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CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Diagnostic Sign of Interstitial Hernia of the Linea Semilunaris

Francis H. Straus, M.D.*, and Merton J. Alexander, M.D.
Chicago

The infrequency of the Spigelian type of hernia in the anterior abdominal wall justifies the reporting of any such case. The following is of additional interest because of the means of establishing the diagnosis and because of the size and content of the sac.

A 77 year old white male was admitted to the Cook County Hospital on 9-13-52. He had been followed in the Cardiac Clinic because of arteriosclerotic heart disease. Cardiac management kept the patient symptom-free. In this clinic it was noted that the patient had a mass in the left lower quadrant of the abdomen.

The patient stated that on 9-3-52 he had a sudden pinching sensation in the left side, and that a lump appeared. Upon lying down, he noted that the pinching sensation went away, but that the lump remained. The bowel movement following this trouble had flecks of red blood upon it; and the patient subsequently became constipated.

Examination revealed an obese elderly male. The blood pressure was 180/100, pulse rate 80, regular. The chest was emphysematous, with a few crepitant rales in the bases. The abdomen was rotund, and there was a small hernia in the umbilicus. In the left lower quadrant, a mass 3 x 3 x 8 cms. was palpable. This was slightly tender, and appeared to be under the fascia when the abdominal muscles were tensed. There was no impulse on coughing or straining. It was irreducible. Bowel sounds could not be discerned. and the percussion note was dull. Rectal examination showed a grade I benign prostatic hypertrophy and a thrombosed external hemorrhoid. The stool was soft and brown.

Laboratory examination revealed a 4+ stool benzidine, and a negative urine. Serological examinations showed a positive Kahn and doubtful Wasserman tests. A barium enema was given. This showed abnormal contour and position of the sigmoid colon, which was diagnostic (Figure 1).

From the Surgical Service of the Cook County Hospital.
*Clinical Professor of Surgery University of Illinois, Medical School, Chicago, Illinois.



Figure 1.—Colon after barium enema. The sigmoid loop extends in the abdominal wall with a long loop convex toward the left. This is a reversal of the usual curve of the sigmoid colon.



Figure 2.—The sac after being dissected free from its interstitial position. The retractors retain the incised margins of the external oblique aponeurosis. The hemostat indicates the apex of the triangular defect in the internal oblique muscle fibers.



Figure 3.—The sac opened, showing adherent sigmoid colon and mesocolon.

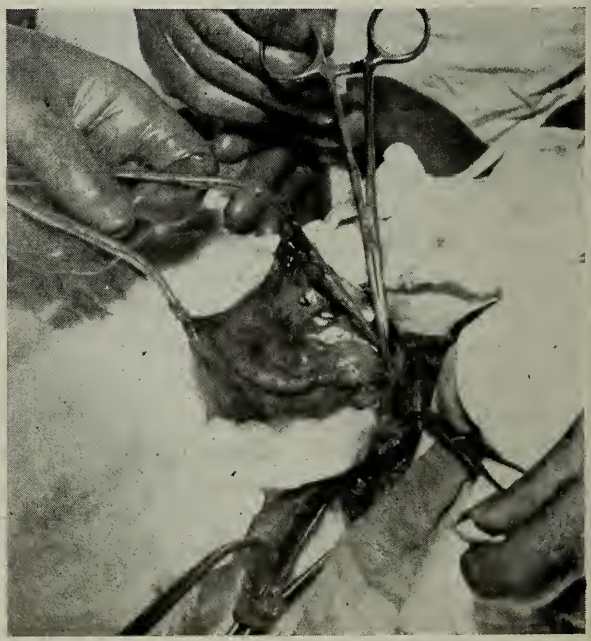


Figure 4.—The sac contents are freed and returned to the abdomen. The hemostat indicates the entrance to the peritoneal cavity.

A diagnosis of Spigelian hernia was made. Under ½% procaine infiltration anesthesia, an incision in the longitudinal axis of the mass (parallel to the fibers of the external oblique muscle) was made. The aponeurosis of the external oblique muscle was incised, and the hernial sac encountered. This sac was dissected to its neck, then opened at the apex. The sac protruded through a triangular defect in the transversalis fascia and the fibers of the internal oblique muscle. The base of this was 2 cms. long and lay parallel to and at the lateral rectus margin. The defect extended to an apex 3 cms. laterally. (Figures 2, 3, 4). The sac was formed by peritoneum and thinned out transversalis fascia. Sigmoid colon filled the sac, and was found to be adherent to the sac wall and to itself. These attachments were easily severed by sharp dissection. After freeing the peritoneum about the neck, the defect was repaired in three layers with interrupted 000 black silk sutures: 1) peritoneum, 2) transversalis fascia and internal oblique aponeurosis, and 3) external oblique aponeurosis. Scarpa's fascia was repaired with interrupted 000 catgut, and the skin with interrupted 00 black silk.

The patient had an uneventful recovery. Follow-up studies showed a more normal position of the sigmoid colon, and the stool benzidine test was negative.

The diagnosis of this mass in the abdominal wall became certain when the films of the barium enema were seen. The history has an interesting sequence, and is almost diagnostic in itself. The contents of the Spigelian herniae are reported as varied: omentum, small bowel, cecum, sigmoid colon. River[6] reports a case in which there was no true sac, but a sliding hernia of the sigmoid colon. The sac with the greatest dimensions at the neck, found in English reports, is that described by Larson[3] where it was 6 x 14 cms.; it contained omentum and the border of sigmoid colon.

Most authors agree to three requisites for the diagnosis of Spigelian hernia:

1) it occurs at the outer border of the rectus muscle
2) it usually is at, or below, the linea semicircularis (fold of Douglas)
3) it is interparietal (interstitial).

A fourth may be added: that the neck be at a juncture of the middle and inner thirds of a line drawn between the umbilicus and the anterior spine of the ilium. This case meets these criteria.

Strictly speaking, a Spigelian hernia occurs through a defect due to segmentation or banding of the muscle fibers of the internal oblique muscle[9]. A sac forms, which does not pass through the strong aponeurosis of the external oblique muscle, but remains under it. Many terms relating to this hernia have been used: hernia of semicircularis Spigelii, of the semilunar line of Spigelius, herniae linea semilunaris. These terms encompass the many herniations that occur along the line of fusion of the transversalis fascia with the internal oblique muscle. The site of fusion parallels the lateral border of the rectus abdominus muscle. It is to be noted that when the neck of the sac is as large as this one, the immediate site of origin cannot be accurately established. Enlargement usually progresses in the line of fibers of the internal oblique muscle.

It is infrequent that one can demonstrate by contrast media bowel which may be present in these herniae, but it was relatively easy in this case. There is no reference to any previous case diagnosed in this manner.

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NEWS OF THE STATE



ADAMS

Society News.—Dr. Norman J. Rose, Chief of the Bureau of Epidemiology, Illinois Department of Public Health, Springfield, discussed the "Treatment of Syphilis Today" before the April 13 meeting of the Adams County Medical Society, Quincy.

COOK

Mt. Sinai Opens New Research Building.—An 11-story Research and Professional Services building was dedicated April 19 by Mt. Sinai Hospital. The $3,400,000. structure was built with the aid of a $2,711,000. grant by the Jewish Federation of Chicago. The building will have no patient beds but will be used solely for service, diagnosis, treatment and research. Features of the new building include an electrokymograph, capable of translating from a "living x-ray picture" a graphic chart of the action of the heart and related organs; an Isotope laboratory using radioactive substances; a special "blue baby" station in the department of cardiology; an enlarged department of pathology for study of blood problems, including the Rh factor; a "recovery room" for patients immediately following their operation. After a few hours they are moved to the main hospital building; a department of physical medicine with hydro-therapy, electro-therapy, special baths, short wave diathermy, and a complete gymnasium; six major operating rooms, wired for color television to be relayed to classrooms in the hospitals and other sections of the city, and animal research quarters on the top floor housing rare breeds of mice, imported and domestic, dogs, cats, ducks, chickens and rabbits.

Frank Newell Joins Chicago Staff.—Dr. Frank W. Newell, associate in ophthalmology at Northwestern University Medical School, has been appointed an associate professor of ophthalmology at the University of Chicago School of Medicine, effective May 1. Dr. Newell, who received his doctor of medicine degree at Loyola University School of Medicine in 1939 and his master of science in ophthalmology at the University of Minnesota in 1942, joined the Northwestern University faculty in 1946.

Personal.—Dr. J. C. Troxel, physician in charge of the Swift and Company medical department, was elected president of Provident Hospital and Training School's board of trustees, succeeding Dr. E. V. L. Brown, recently deceased.—Walter W. Dalitsch, M.D., D.D.S., associate professor of oral surgery, was recently appointed associate director of the Cleft Lip and Palate Institute of Northwestern University. —Dr. Albertine L. Rea was chosen to represent Illinois at the First Western Hemisphere Conference of the World Medical Association in Richmond, Va., April 23-25. All physicians representing the states at the conference were born in the year 1878.

Dr. Bettag Honored.—Dr. Otto L. Bettag, state director of welfare, was guest of honor at a dinner, April 23, at the Edgewater Beach Hotel. Dr. Herman N. Bundesen and Philip Weber, directors of the Municipal Tuberculosis Sanitarium, faculty members of local medical schools and 200 staff physicians, nurses and employees of the sanitarium, gave the dinner as a testimonial to Dr. Bettag. Dr. William M. Lees, chief of surgery at the sanitarium was toastmaster.

Borden Awards for Pediatric Residents.—On April 21 the Chicago Pediatric Society honored the three winners in the annual Borden Awards for

Pediatric Residents. Dr. Dorothy Lynch, University of Illinois College of Medicine, was chosen for her paper on "Genital Syndromes in Childhood and Adolescence"; Dr. Robert Mendelsohn, Michael Reese Hospital, for his work on "The Subcutaneous Administration of Terramycin", and Drs. Thomas Baffes and Frank Johnson, Children's Memorial Hospital, for their presentation on "Anatomic Variations in Tetralogy of Fallot." Each year the Borden Company makes available $250 through the Chicago Pediatric Society for residents in the hospitals and medical schools of the Chicago area. The department head of each chooses the best presentation. In the current awards four persons will share the $250.

Million Dollar Nursing Home for Alexian Brothers Hospital.—Ground will be broken August 2 for a one million dollar nurses school, residence and recreation center at Alexian Brothers Hospital, newspapers report. In addition to accommodations for one hundred students, the structure will provide space for administrative offices, lounges and other quarters. The educational section will include lecture halls, laboratories and faculty offices. Classrooms will be air conditioned and equipped with the most advanced illumination. Construction, newspapers reported, will be financed principally through a mortgage on the hospital's present property, marking the first time in fifty-six years that the Alexian Brothers have had an encumbrance on their buildings. It was also stated that aid will come too from the hospital's foundation, an organization of Chicago business and professional men who through various fund raising activities have contributed $250,000. to the hospital in the last five years. Alexian Brothers Hospital is said to be Chicago's third oldest hospital.

Annual Davis Lecture.—"Changing Concepts in American Medicine Over Three Centuries" was the title of the Tenth Annual D. J. Davis Lecture on Medical History delivered at the University of Illinois College of Medicine, May 6. The lecturer was Richard H. Shryock, Ph. D., Director, Institute of the History of Medicine, Johns Hopkins University.

First Hektoen Memorial Lecture.—Dr. Paul Klemperer, pathologist of the Mount Sinai Hospital, New York, and professor of pathology of Columbia University College of Physicians and Surgeons, delivered the First Ludvig Hektoen Memorial Lecture at Cook County Hospital, May 14, on "Collagen Diseases—Evolution of the Concept". The lecture was established by the Hektoen Institute for Medical Research of the Cook County Hospital.

Illinois Physicians Honored.—Dr. Max S. Sadove, head of the department of anesthesia, University of Illinois College of Medicine, was chosen president of the Walter Reed Society at a meeting in Chicago, April 8. Dr. Y. T. Oester, head of the department of pharmacology, Stritch School of Medicine of Loyola University, was named vice-president and Dr. Frances A. Hellebrandt, director of the department of physical medicine and rehabilitation at Illinois, was elected secretary-treasurer.

Society News.—Dr. Maurice H. Cottle discussed "The Role of the Rhinologist in Rhinoplasty" at a meeting of the American Laryngological Rhinological and Otological Society in New Orleans recently.—The Medical Staff of the Highland Park Hospital, Highland Park, was addressed April 18 by Dr. Louis B. Newman, Chief of the Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Hines. His subject was "Physical Medicine and Rehabilitation as part of Total Medical Care".—Dr. Leon Unger has returned from an around the world trip during which time he delivered seventeen speeches before various medical societies in Hawaii, Japan, Hong Kong, Siam, Pakistan; Calcutta, New Delhi and Poona in India, Haifa and Jerusalem in Israel and Athens, Greece. Many of these meetings were held under the auspices of the American College of Chest Physicians and the subjects covered were various aspects of bronchial asthma and migraine.

New Residence Hall at County Hospital.—Cook County's new three million dollar, fifteen story residence hall for interns and resident physicians at Cook County Hospital was dedicated May 3, the Chicago Tribune reported. The building, named the Dr. Karl A Meyer hall in honor of the chief of the hospital's surgery department and also medical director of all county institutions, is connected to the main hospital by a tunnel. The hall contains 280 single rooms with a bath between every two rooms, twelve two room apartments and five five room units for married staff members. It also has a visitors' lounge which county officials furnished as though it were an exclusive club, a gymnasium, handball courts, game rooms, cafeteria dining room and a snack bar, several class rooms and a hall of fame displaying portraits of doctors. Dr. Frederick Tice, who has served the hospital many years as a consultant, was also honored by the naming of a medical library in the building in his honor. The residence hall will enable the hospital to expand its capacity for patients by 250 beds when all interns and patients have moved out. The vacated rooms, according to the Tribune, will be rehabilitated and converted for patient use.

Dr. Huggins Honored.—Dr. Charles B. Huggins, professor of surgery, University of Chicago School of Medicine received the third annual Bertner medallion, newspapers reported recently. The ceremony to present the award took place May 15 in Houston, Texas, at which time Dr. Huggins delivered the annual Bertner lecture sponsored by the University of Texas Hospital.

University News.—Dr. Armand J. Quick, professor of biochemistry, Marquette University School of Medicine, Marquette, Wisconsin, gave the Uni-

versity lecture hour, May 13, at the University of Illinois College of Medicine. Dr. Quick's subject was "The Coagulation of the Blood and Its Clinical Implications."

Winners in Essay Contest by Interns and Residents.—At the regular meeting of the North Shore Branch of the Chicago Medical Society at the Edgewater Beach Hotel, May 5, the winners of the Annual Competition by Interns and Residents of the Chicago Hospitals were announced. Thomas G. Baffes and Frank R. Johnson, Children's Memorial Hospital and the Otho S. A. Sprague Memorial Institute Laboratory, won first prize of one hundred dollars with their presentation on "Anatomic Variations in Tetralogy of Fallot". Second prize of fifty dollars went to James B. McCormick, resident in pathology at Augustana Hospital, for his presentation on "Quantitative Gonadotropine Studies in Urine and Spinal Fluid in Chorionic Moles and Choriocarcinomas". Meyer Markovitz, resident in medicine, Research and Educational Hospitals, University of Illinois College of Medicine, received third prize money of twenty-five dollars for his work on "Coexisting Diabetes Mellitus and Addison's Disease—A Report of Two Cases". Other prize winners were Minas Joannides, Jr., Veterans Hospital, Hines and Peter C. Rumore, also of the Veterans Hospital, for their work on "Mediastinal Tumors" and "External Pancreatic Fistulas—With Observations on Two Cases", respectively.

This Annual Competition is sponsored by the North Shore Branch of the Chicago Medical Society. The papers were given by the respective authors in twenty minute presentations each and were judged by Drs. Ford K. Hick, Anders Weigen and Richard Young.

University Appointment.—Dr. Paul B. Szanto has been appointed clinical assistant professor of pathology at the University of Illinois College of Medicine. Dr. Szanto, 48, recently was appointed chief pathologist of the Chicago State Tuberculosis Sanitarium. In this capacity, it is anticipated that he will contribute to the educational program of the College of Medicine. He has served as associate director, senior pathologist at Cook County Hospital since 1946. He taught at Northwestern University between 1946 and 1952. Dr. Szanto is the author of numerous scientific papers. He received the doctor of medicine degree at Vienna, Austria, in 1929.

DU PAGE

Society Meets at Argonne Laboratory.—The Du Page County Medical Society met on April 15th at the Argonne National Laboratory, the nation's oldest atomic energy research and development laboratory. Seventy members of the Du Page County Medical Society began the meeting at 4:30 p.m. which included a tour of the newly constructed biological and medical research facilities, among which were the electron microsope, the animal farm, counting rooms, bioassay "hot" laboratory, and the gamma ray exposure facilities.

Following dinner in the Laboratory's dining room, Dr. Samuel K. Lewis, President of the Society, conducted a business session highlighted by a presentation of the Illinois State Medical Society's 11th District Councilor, Edwin S. Hamilton, M.D. of Kankakee, Illinois, and Walter H. Zinn, Director of the Laboratory.

The scientific meeting included "Medical Applications of Radioactive Isotopes" by Austin H. Brues, M.D., Director of the Laboratory's Division of Biological and Medical Research, and "Recent Toxicological Studies of Radium" by Robert J. Hasterlik, M.D., Director of the Laboratory's Health Services Division.

The Argonne National Laboratory is located in Du Page County and many of the physicians on its staff are members of the Du Page County Medical Society. Emphasis was given throughout the meeting to continued cooperation between the members of the Laboratory staff and the professional men of the community in regard to the useful and unique information to be had at the Laboratory.

LIVINGSTON

Special Ceremonies Observe Opening of New Hospital Wing.—The new forty bed wing of St. James Hospital, Pontiac, was opened with appropriate ceremonies in a two day celebration, May 28-29. A five o'clock tour of the hospital preceded a social hour and dinner, May 28, attended by community leaders and hospital officials. Highlighting the dinner was an address by George M. Cummins, M.D., associate in medicine, Northwestern University Medical School, on "Recent Medical Accents." Dr. Cummins appeared under the auspices of the Educational Committee of the Illinois State Medical Society.

A dedicatory Mass, officiated by the Reverend Bishop Cousins of Peoria, preceded the formal dedication of the new wing, Friday morning, and a dinner at 1 p.m. for all those in the community who had taken active leadership in obtaining the necessary funds to finance the wing's construction.

Members of the staff of St. James Hospital and members of the Livingston County Medical Society acted as hosts for the two day celebration. Dr. Michael J. Lavin headed a committee to arrange the program Thursday evening. Those present included Dr. Joseph T. O'Neill, Ottawa, Councilor for the Second District of the Illinois State Medical Society.

The new wing gives a total of eighty beds to the hospital. Two floors, housing surgical and obstetrical facilities, will not be completed until more funds are avaiable.

MADISON

Society News.—Dr. E. Lee Strohl, clinical associate professor of medicine, University of Illinois College of Medicine, addressed the Madison County Medical Society at St. John's Methodist Church,

Edwardsville, May 7, on "Symptoms of Common Duct Stones".

ROCK ISLAND

Society News.—Dr. Walter C. Alvarez, editor and chief of Modern Medicine and Geriatrics, Chicago, addressed the Annual Meeting of the Iowa-Illinois Central District Medical Association at the Plantation, Moline, May 8, on "How Do Women Get So Nervous?". The discussion was opened by Dr. George Braunlich, Davenport, Iowa. Dr. Ralph K. Ghormley, Rochester, Minn., addressed the society, April 14, on "Late Joint Changes as a Result of Internal Derangement of the Knee".

SANGAMON

Society News.—The Sangamon County Medical Society was addressed at a dinner meeting in the Elks Club, Springfield, by Dr. Justin J. Cordonnier, professor of urology, Washington University School of Medicine, St. Louis, on "Renal Injuries".

VERMILION

Society News.—Dr. Hans Reese, head of the Department of Neurology and Psychiatry, University of Wisconsin Medical School, Madison, addressed the Vermilion County Medical Society, meeting conjointly with the staff of the Veterans Administration Hospital, at a meeting at the Hotel Wolford in Danville, May 5. His subject was "What's New in Neurology and Psychiatry". Other speakers before the society recently were Drs. Erich M. Uhlmann, Michael Reese Hospital, Chicago, on "Differential Diagnosis of Lesions About the Face and Mouth", and Paul S. Rhoads, Chicago, on "Anti-bacterial Management of Urinary Tract Infections".

WINNEBAGO

Societies Hold Joint Meeting.—At a meeting of the Winnebago County Medical Society in conjunction with the local Tuberculosis Association, recently, in Rockford, Dr. E. Grunberg spoke on "Evaluation of New Drugs" and Dr. C. P. Bailey, Philadelphia, "Recent Trends in Cardiac Surgery". An X-ray Conference was a feature of the program. At the banquet in the evening, Arthur F. Gerecke, who was on leave of absence from the St. Louis Post-Dispatch, and attached to General Eisenhower's Supreme Command, spoke on "The Kremlin vs. We The People". The county medical society was addressed, April 14, on "Inter-Professional Relationship of Doctors and Lawyers." The speaker was Attorney John W. Freels.

GENERAL

Meeting of Health Officers.—At the spring meeting of the Illinois Association of Medical Health Officers in Chicago recently in conjunction with the annual meeting of the Illinois Public Health Association, Dr. E. M. Thompson, health officer, in charge of the DeWitt-Piatt Bi-County Health Department, Clinton, was installed as president; Dr. Fred Long, health officer of Peoria County and Peoria City Health Department, Peoria, was named president-elect and Dr. Herbert Ratner, Health Commissioner of Oak Park, was elected secretary-treasurer. Other members of the executive committee are: Dr. S. N. Mallison, health officer in charge of East Central Regional State Office, Champaign; Dr. L. L. Fatheree, health officer in charge of Will County Health Department, Joliet; Dr. E. A. Piszczek, Executive Director, Suburban Cook County Tuberculosis Sanitarium District, Forest Park.

The Illinois Association of Medical Health Officers consists of full-time medical public health personnel of the State, District, County, and Municipal Health Departments, and physicians on a full-time basis as teachers of public health or in school health services. The purpose of the organization is to further public health practices, to consider questions relating to practical adminstration of public health, hygiene and sanitation, to provide consultation to State and local public health agencies, to make recommendations regarding standards, rules and regulations, and to undertake such other functions as will promote better public health organization in the State of Illinois.

Meeting of Proctologists.—The Fifth Annual Convention of the International Academy of Proctology was held at the Plaza Hotel, New York City, May 29-31. The meeting was extended to include a Surgical Clinic and Seminar at Jersey City Medical Center under the direction of Dr. Earl J. Halligan. An extensive Motion Picture Seminar of Proctologic Surgery (including office techniques) was held on May 31st. All scientific papers presented the latest developments in proctology and gastroenterology.

Because general practitioners, as well as gastroenterologists and proctologists, face proctologic problems in their daily practice, much of the program was planned to answer their questions.

"How's Your Health" over WGN-TV.—**"How's Your Health"**, produced by the **Educational Committee** of the **Illinois State Medical Society**, in cooperation with **WGN-TV**, has presented the following telecasts:

Edwin F. Hirsch, director, Henry Baird Favill Laboratory, St. Luke's Hospital, and William W. Bolton, associate director, Bureau of Health Education, AMA, April 20, "Your Doctor's Laboratory."

Fletcher Austin, instructor in otolaryngology, Northwestern University Medical School, April 27, "Blocked Ears."

William A. Larmon, associate in bone and joint surgery, Northwestern University Medical School, May 4, "When a Disc Slips."

Thomas J. Naughton, clinical instructor in ophthalmology, Stritch School of Medicine of Loyola University, May 11, "Contact Lenses."

"Your Doctor Speaks" over FM Station WFJL.—In the radio series **"Your Doctor Speaks"** over **FM Station WFJL**, the following physicians ap-

peared in transcribed broadcasts under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Alex J. Arieff, assistant professor of nervous and mental diseases, Northwestern University Medical School, April 23, on "Neurology and Psychosomatic Medicine."

Robert H. Ebert, instructor in medicine, University of Chicago School of Medicine, April 30, on "Tuberculosis."

Harry E. Barnett, member, attending staff, Michael Reese Hospital, May 7, on "Common Orthopedic Deformities of Infancy and Early Childhood."

Matthew J. Brunner, attending staff, department of dermatology, Northwestern University Medical School, May 14, on "Warts, Birthmarks and Moles."

"All About Baby" on WBKB.—Early in 1952, after careful and extensive study, the **Educational Committee** of the **Illinois State Medical Society** agreed to cooperate with the Herbert S. Laufman and Company (Television Advertising Productions) in a series "All About Baby", featuring Ruth Crowley, R.N., Oak Park. The series was launched on WNBQ as a public service by the television agency and NBC. Acting on the stipulation of the Educational Committee that physicians be paid on any program where all other participants were paid, the agency compensated all physicians who appeared on "All About Baby" at the request of and under the auspices of the Educational Committee. Under this format the program was a feature of the weekly series "Good Living" and ran for approximately a year.

"All About Baby" then left the air to return on another station, Channel 7, ABC outlet WBKB. **Mead Johnson Company** is sponsoring three programs of the five fifteen minute telecasts each week. The **Educational Committee** again reviewed the various aspects involved in a commercial sponsorship and set forth certain stipulations concerning the way in which the commercial should be handled on the day the physician was a participant. Ruth Crowley, R.N., delivers the commercial copy informally, the physician does not appear before the viewing audience when it is given, and no implication is made that either the physician or the Educational Committee is endorsing the product, which is Pablum.

The method of handling and acceptance by all concerned, **Mead Johnson & Company,** the **Herbert Laufman Company** and the Educational Committee of the Illinois State Medical Society testifies that matters medical can be presented to the public on a dignified and high plane. The viewing audience, under the new format with commercial sponsorship, is now told that the physician is appearing under the auspices of the Educational Committee of the Illinois State Medical Society. Physicians who have appeared on "All About Baby" both on WNBQ and WBKB are: Eugene T. McEnery, Larence Breslow, John Coughlin, George Eisenberg, L. Martin Hardy, Arthur H. Rosenblum, John L. Reichert, Hoseph N. Rappaport, Jeanne Mercer, H. William Elghammer, John S. McDavid, Joseph A. Bertrucci, Irving R. Abrams, Matthew Steiner, Margaret M. Scannell, Robert K. Hagan, Leonard L. Braun, Karl Vehe, Edmond R. Hess, Anders J. Weigen, Howard M. Jacobs, Arthur W. Fleming, Robert A. McGuigan, Edward K. Isaacson, Frank M. Quinn, Rudolph Dreikurs, Harry T. Nagel, Louis D. Minsk, Joseph T. O'Neill, James A. Conner, Eugene Slotowski, Joseph R. Christian, Frank E. Doyle, Harry Boyle, Alfred S. Traisman, Herbert F. Philipsborn, Paul C. Tracy, Herman F. Meyer, Maxwell P. Borovsky, Harry L. Faulkner, Marvin P. Padorr, Arthur L. Shafton, Carl Marienfeld, Emerson K. McVey, Paul K. Anthony, John M. Reichert, Mildred R. Jackson, Ralph H. Kunstadter, Ralph Spaeth, and Adolph R. Nachman.

The Educational Committee schedules these physicians for "All About Baby" just as it does for its other activities. The invitation is issued by telephone and letters of confirmation are then sent to the physician and the Herbert Laufman Company.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Morris Braude, Howland PTA in Chicago, May 12, on Mental Hygiene.

George V. Byfield, Bethel Lutheran Ladies Aid, May 13, on Geriatrics.

The Committee also scheduled the following Youth Week Lectures for the Chicago Board of Education and the Chicago Medical Society:

Donald A. Dukelow, Wells High School, May 11, Teen Age Tips in Health.

Paul K. Anthony, Bradwell School, May 12, Teen-Age Tips on Health.

Fred V. Hein, Ph.D., Wells High School, May 12, Building Body Bones and Beauty.

Edward W. Beasley, Doolittle School, May 13, Health and Personality Development.

Lawrence Breslow, Prescott School, May 13, Health and Personality.

Robert K. Hagan, Washburne Trade School, May 13, on Health and Personality.

John P. Coughlin, Wells High School, May 14, How Temperamental Are You?

W. K. Gottstein, McClellan Elementary School, May 14, on Keeping Solid with Health.

William W. Bolton, Wells High School, May 15, Health and Personality.

Alfred D. Biggs, Hedges Elementary School, May 15, on Teen Age Tips on Health.

Emerson K. McVey, Cornell Elementary School, May 15, How Temperamental Are You?

Robert E. Lee, Yale Elementary School, May 21, Health and Personality.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Earle E. Wilson, Oak Park, Rock Island Chapter of the Illinois Academy of General Practice at the Plantation Club, Moline, April 28, on Fear: An Emotional Habit.

Willard Van Hazel, Chicago, DeKalb County Medical Society in Sandwich, May 26, on Bronchiogenic Carcinoma.

David N. Danforth, Evanston, Bureau County Medical Society in Princeton, June 9, on Analgesia and Anesthesia in Obstetrics.

DEATHS

Lewis D. Barding, East Moline, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died April 14, aged 65. He was a member of the staffs of the Lutheran, St. Anthony's and the Moline Public Hospitals, serving as president of the latter in 1935.

Anna Ellsworth Blount, retired, Oak Park, who graduated at Northwestern University Woman's Medical School in 1897, died in Wisconsin, February 12, aged 81. She was a past president of the Medical Women's National Association and served on the staffs of the Women's and Children's Hospital in Chicago and the West Suburban Hospital, Oak Park.

Frank C. Bowker, Morris, who graduated at the Hahnemann Medical College and Hospital in 1899, died March 28, aged 80. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Toney T. Crooks, Chicago, who graduated at Rush Medical College in 1923, died May 9, aged 67. He was a member of the staff of the Norwegian-American Hospital.

Elijah Rockhold Crossley, Chicago, who graduated at Northwestern University Medical School in 1902, died January 23, aged 83. For many years he was affiliated with the Illinois Eye and Ear Infirmary.

Frank N. Davenport, Moline, who graduated at Northwestern University Medical School in 1910, died February 3, aged 68.

Andrew Ross Ferguson, Orland Park, who graduated at Northwestern University Medical School in 1949, died February 20, aged 29.

Noah Fox, Chicago, who graduated at Rush Medical College in 1922, died April 9, aged 56. He was on the staffs of Mother Cabrini and Jackson Park Hospitals, and clinical assistant professor of otolaryngology at the University of Illinois College of Medicine.

Alfred Herman Hallman, Chicago, who graduated at Rush Medical College in 1922, died February 15, aged 55, of acute coronary thrombosis. He was associate professor of medicine at the Chicago Medical School, president of the Northwest Regional Illinois Chapter of the American Academy of General Practice, and past president of the Northwest Branch of the Chicago Medical Society.

William Nelson Hamilton, Salem, who graduated at St. Louis University School of Medicine in 1903, died October 11, aged 85.

William L. Hercik, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died April 3, aged 66.

Rudolph W. Holmes, retired, formerly of Chicago, who graduated at Rush Medical College in 1893, died at his home at University, a suburb of Charlottesville, Va., April 24, aged 80. He was professor of obstetrics and gynecology at Rush Medical College for more than 30 years and had been associate professor in the same department at Northwestern University Medical School.

Doctor C. Hoyt, Chicago, who graduated at Rush Medical College in 1902, died recently, aged 77.

William M. Jones, Chicago, who graduated at Chicago Medical School in 1926, died April 21, aged 55.

Raymond Hussey, Chicago, who graduated at the University of Maryland School of Medicine, Baltimore, in 1911, died in St. Luke's Hospital, April 15, aged 69. He was scientific director of the Council on Industrial Health of the American Medical Association.

Anna Ross Lapham, retired, Chicago, who graduated at Northwestern University Woman's Medical School in 1898, died March 31, aged 83. She joined the faculty of Northwestern in 1919, and became professor emeritus in obstetrics in 1946.

Albert R. Lemke, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1899, died May 11, aged 76.

Dr. Sol Litt, Chicago, who graduated at Rush Medical College in 1926, died April 6, aged 53.

Margaret Mary Livingston, Chicago, who graduated at Bennett Medical College in 1909, died February 2, aged 87, of arteriosclerotic heart disease.

Werner Lonsen, Elgin, who graduated at Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, in 1917, died February 8, aged 59, of coronary disease.

Paul T. Lyon, Chicago, who graduated at Northwestern University Medical School in 1903, died May 6, aged 74. He was a member of the staff of Garfield Park Hospital.

Robert F. McNattin, Chicago, who graduated at Washington University School of Medicine in 1928, died May 9, aged 50. He was director of therapeutic radiology at Cook County Hospital from 1935 to 1945.

Amos Foster Moore, Dixon, who graduated at Marion-Sims College of Medicine, St. Louis, in 1895, died January 2, aged 85, of coronary insufficiency and hypertension.

Eugene B. Perry, Chicago, who graduated at Rush Medical College in 1917, died May 11, aged 59. He was assistant professor of urology at Northwestern University Medical School.

William Clement Stein, Chicago, who graduated at Rheinische Friedrich-Wilhelms Universität Medizinische Fakultät, Bonn, Prussia, in 1920, died in the Manor Hospital, February 15, aged 61, of coronary thrombosis.

Matthew William Withers, Joliet, who graduated at Meharry Medical College, Nashville, in 1918, died January 1, aged 60, of acute myocardial failure.

Louis H. Wolf, Chicago, who graduated at Northwestern University Medical School in 1909, died April 12, aged 66.

Frank K. Xavier, Chicago, who graduated at the University of Illinois College of Medicine in 1935, died April 17, aged 54.

MARRIAGES

Raymond W. McNealy, Chicago, to Dorothy Currey Frazier, March 19.

CHRONIC LEUKEMIA

A great deal can be accomplished in the treatment of chronic leukemia if it is borne in mind that present treatment is palliative. The whole patient, rather than the diagnosis of the leucocyte content of the blood, should be treated. Osgood recommended the treatment of chronic leukemia from the date of discovery, regardless of symptoms. He maintained that patients can be kept in happier and more productive states during their remaining years by this method. He emphasized follow-up at intervals regularly spaced to determine the effects of radiation before further treatment is applied. Block and Jacobson expressed the opinion that specific therapy should be reserved for patients with symptoms of active disease, an opinion concurred in by the majority of investigators. Ross and Ebaugh noted that available specific agents destroy normal as well as neoplastic cells and suggested that they be used with care. *Arthur A. Marlow, M.D., and Grant R. Bartlett, Ph.D., Newer Therapy For Leukemia, Poly-Cythemia, And Lymphoma. California Med., Feb. 1953.*

ELBOW INJURIES IN CHILDREN

Elbow dislocations in children and adolescents may be associated with fracture of the medial epicondyle, which lesions may also occur independently. Except for the fairly frequent accompaniment of the epicondylar lesion in the early age group, the clinical characteristics of elbow dislocations before and after skeletal maturity are the same. Prompt and gentle reduction is indicated. This requires relaxation, whether gained by general anesthesia or by other means. Once relaxation is gained all that usually is required for reduction is gentle traction. Milch has described a prone relaxation reduction of shoulder dislocations without anesthesia and without pain to the patient. A technique practically identical to this has been used recently in elbow dislocations, one in a child and one in an elderly woman, and in both instances found to be effective. Following reduction of the dislocation, the joint is immobilized for a week or ten days. A sling is adequate for this purpose. Flexion beyond 90 degrees is unnecessary, and is particularly hazardous where appreciable swelling is present. *Robert P. Kelly, M.D., and Tom S. Howell, M.D., Elbow Injuries. South. Med. & Surg., Jan. 1953.*

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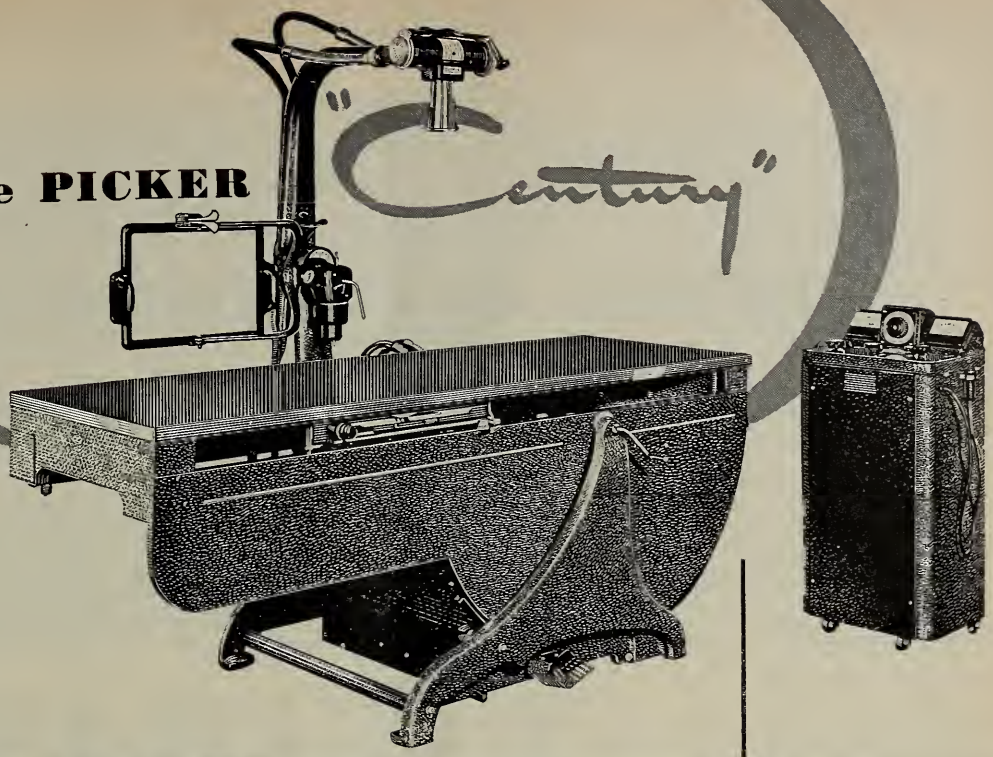
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ST. LOUIS 10 (Southern) MISSOURI, 4120 Clayton Avenue

PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



MEDULLARY FIXATION OF FRACTURES OF THE LONG BONES

Rufus H. Alldrege, M.D., Daniel C. Riordan, M.D., and Crampton Harris, M.D. In NEW ORLEANS MEDICAL AND SURGICAL JOURNAL, 104:15: 619, September 1952.

Medullary fixation of the long bones was first attempted many years ago, only to be discarded for other methods, for reasons which are not entirely clear at this time. During the past ten years the method has been improved and standardized, until at present it is regarded as a sound and comparatively safe procedure, commonly employed by orthopedic surgeons in many parts of the world.

Medullary fixation by pin or nail combines four principles of fracture treatment which, particularly in fractures of the femur, cannot be accomplished as well by any other means:

(1) Simplicity, adaptability, and safety to the patient during application of the technique.

(2) Accurate reduction of the fracture.

(3) Good, reliable, anatomical reduction of the fragments, with dependable maintenance of position, without distraction, and with provision for impaction of the ends of the fragments through exercise and weight bearing.

(4) Early postoperative use of the muscles and joints, and early weight-bearing.

In fractures of the femur, medullary fixation has notable advantages. As external fixation, traction, splints, plaster casts, or bed traction are not required postoperatively in most cases treated by this method, frequently, the patient may begin actively moving the part on the second or third postoperative day. When medullary fixation of the femur is accomplished soon after the occurrence of the fracture, exercise of the limb with full range of motion in all joints of the extremity may be undertaken in bed on the first or second postoperative day. In other cases, bed exercises may be started between the third and seventh days, depending on the needs and limitations of the individual patient. It is desirable for many to begin ambulation with crutches on the fifth or sixth day, and light weight-bearing with crutches after the seventh or eighth day. Thus, the usual muscle wasting and atrophy are avoided, and the possibility of joint fibrosis, or stiffness, is eliminated. The function of the limb is fully maintained while healing takes place, and the early weight-bearing with support (such as crutches) causes impaction of the ends of the bones, which actually hastens healing. The enormous benefits and advantages to the patient are self-evident.

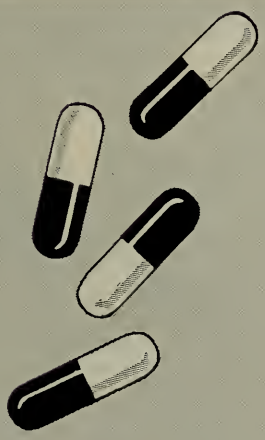
The authors have summarized their experience with the use of medullary fixation for fractures and certain conditions of the femur and the other long bones, over a period of six years.

(*Continued on page* 42)

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Physical Medicine (Continued)

Medullary fixation of the long bones is a highly technical, precision type of procedure, which is potentially attended by probably more difficulties and errors than any other method used since internal fixation was first introduced into surgery. It hardly seems necessary to say that the procedure should be undertaken only by physicians who are experienced in the surgical care and treatment of fractures, and only in hospitals where the special facilities necessary for the management of such cases are readily available.

However, when the procedure is properly carried out, from the primary consideration of selecting the patient, to the final detail of postoperative care, the patient may derive greater benefits from this method than from any other for the treatment of fractures of the long bones, particularly fractures of the femur.

REHABILITATION OF THE TUBERCULOUS PATIENT

A. Ray Dawson, M.D., and B. B. Bagby, Jr., M.D. In VIRGINIA MEDICAL MONTHLY, 79:4:179, April 1952.

The concept of medical rehabilitation in the complete treatment of tuberculosis is not new, nor is the criteria on which to base the efficiency of this treatment new. Although medical rehabilitation begins during the treatment of the active phase of tubercuosis, this paper is limited to that phase of rehabilitation which is normally carried out in a specialized rehabilitation center.

The concept of activities of a tuberculosis rehabilitation center is based on the premises that the long accepted method of "walking exercises" is not an entirely adequate means of determining work tolerance, since such exercise alone makes it difficult to determine objectively a particular patient's capacity to work or study in a specific field following discharge. On the surface, it would seem that the activities of a tuberculosis rehabilitation center deal primarily with the hardening process and the determination of vocational aptitudes and abilities. However, there is under the surface and running throughout the center's stay, a purposeful teaching procedure which has as its objective teaching the patient the art of living following a severe debilitating disease. Patients are taught the signs of fatigue, that rest must become a part of their daily life, and that emotional stresses are of major importance. The techniques of rehabilitating the tuberculous patient fall under the heading of controlled environment and teaching the patient to live again. Although controlled environment in itself hastens complete recovery, it is used in a rehabilitation center as much for teaching the patient how to live again as for the purpose of hastening recovery. Patients are required to take prescribed periods of rest each day. Their respiration and pulse are taken before and after a work experience. Should the respiration and pulse show a sharp rise, it is indicative both to the therapist and to the patient that he is exceeding fatigue limits. The ex-tuberculous patients must learn that a steady flow of work within fatigue limits assists in maintaining the healed process, but that peak loads of work are dangerous.

A statistical study of tuberculosis patients indicates that medical rehabilitation, as a part of the complete treatment, lessens reactivation and that the investment of time and money in this form of treatment returns handsome dividends.

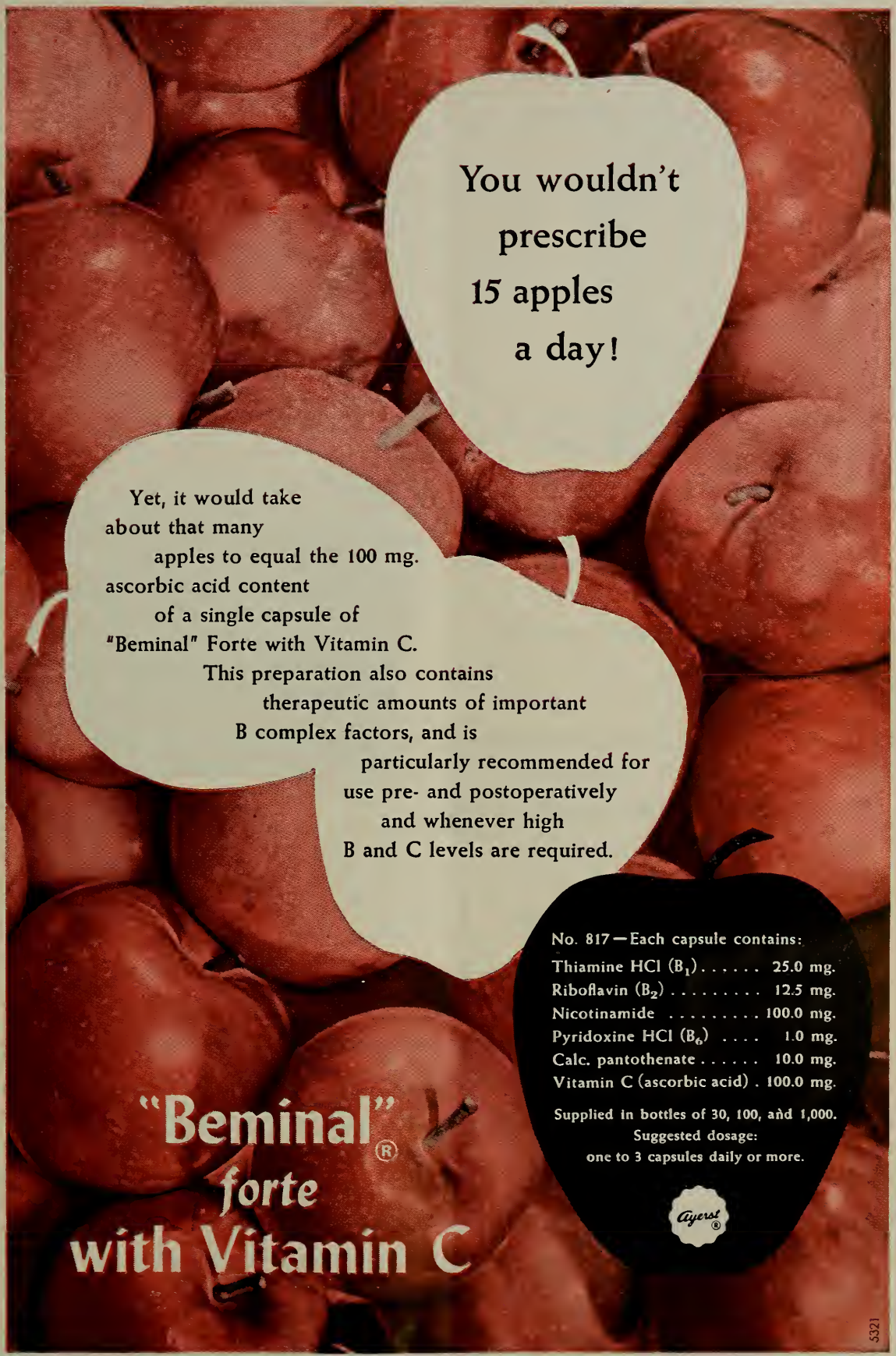
INCIDENCE OF POLIOMYELITIS: THE EFFECT OF TONSILLECTOMY AND OTHER OPERATIONS ON THE NOSE AND THROAT

Alden H. Miller, M.D., Los Angeles. In CALIFORNIA MEDICINE, 77:1:19, July 1952.

Operations on the nose and throat, especially tonsillectomy and adenoidectomy, have been accused of increasing the incidence of poliomyelitis. A recent review of several articles on the subject showed that opinions were about evenly divided as to whether or not poliomyelitis is more likely to occur in persons who have had tonsillectomy and adenoidectomy, either recently or in the more remote past. Also most of the investigators believed that if poliomyelitis is contracted soon after these operations, there is increased possibility that the disease will be of the bulbar type.

A continuing three-year statistical study of complete data on all cases of poliomyelitis occurring in the entire county of Los Angeles during the years 1949, 1950 and 1951 was carried out. There were a total of 3,601 cases of polio-

(*Continued on page* 44)



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Physical Medicine (Continued)

myelitis, but only 20 of this number (0.55 per cent) had had recent operation for tonsils or adenoids.

In a separate survey of 675 patients with poliomyelitis, it was noted that only 30 per cent ever had had tonsillectomy or adenoidectomy. Inasmuch as it is estimated that one of every three persons in the general young population nowadays has had tonsillectomy and adenoidectomy, this figure is no more or less than could be expected.

It was concluded that operations on the nose and throat, including tonsillectomy and adenoidectomy, either recent or done long before, had no significant effect, statistically, on the incidence of poliomylitis in Los Angeles County during the three-year period 1949-1951.

CLINICAL EFFECT OF ULTRASONIC WAVES IN CHONDROMALACIC AND OSTEOARTHRITIC CHANGES IN THE KNEE

Olov Lindahl. In RHEUMATISM, 8:2:36, April 1952.

In order to obtain a more objective assessment of the value of ultrasonic energy, a series of patients with pain in the knee-joints have for a little more than a year been treated with ultrasonic waves in the orthopedic department of St. Gorans Hospital in Stockholm. During this period the patients received no other therapy. In most cases the pain was of many years' standing and the earlier treatment of short-wave, x-ray and physical therapy had had only transient or no effect. Painful conditions of specific nature, which were due to tumors, tuberculous or other infection, were not included. The complaints were of common type, with pain in the knees aggravated on exertion and walking, in many cases most noticeable on walking up or down a flight of stairs.

The patients were examined before the treatment was started, and subjective and objective symptoms were recorded, in all cases by the same examiner. The patients were then given a total of ten treatments, three each week. The moving technique was used in applying the ultrasonic vibrations, and the period of application was successively increased from 8 to 12 minutes. About a week after the termination symptoms

(*Continued on page* 46)

50 YEARS AGO

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(1) Cheadle—*Artificial Feeding and Food Disorders of Infants*, Sixth Edition (1906)

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were again recorded. A similar re-examination was done after another month.

About half the number of the treated patients were given so-called O-treatment, that is, the control lamp was alight but the effect was adjusted to minimum strength and the crystal was not tuned in. These cases were chosen at random in the therapy department and the examiner did not know the nature of the treatment. Otherwise the usual procedure was employed and it was not possible for the patients to check the adjustment of the apparatus.

Up to the present 40 patients have been treated and the material has been analyzed. The results obtained so far show that no essential changes in the objective symptoms occurred during the period of treatment, nor was any significant difference in the objective and subjective symptoms demonstrated at the re-examinations. With regard to the subjective symptoms 17 had marked improvement, 10 improvement, 6 slight improvement, and 7 no change.

So, in this experiment, with the dosage used, the application of ultrasonic energy had no significant therapeutic effect on the pain in cases of malacic and osteoarthritic changes of the knee-joints. The percentage of improvement and no change quoted here may therefore be said to represent the power of spontaneous remission of the symptoms.

Ultrasonic energy also was used on ten patients with painful conditions of neuralgic and rheumatic character, for example, sciatica and brachialgia. The patients selected for this experiment had long-standing persistent pain and had received all the usual forms of treatment without any effect. Application of ultrasonic vibrations had a beneficial effect on all these cases. This is based on relatively small material and cannot be considered to be significant; nevertheless, Lindahl believes that, although its value in cases of pain in the knee is uncertain, treatment with ultrasonic energy may have a lasting effect in painful conditions of neuritic and neuralgic character.



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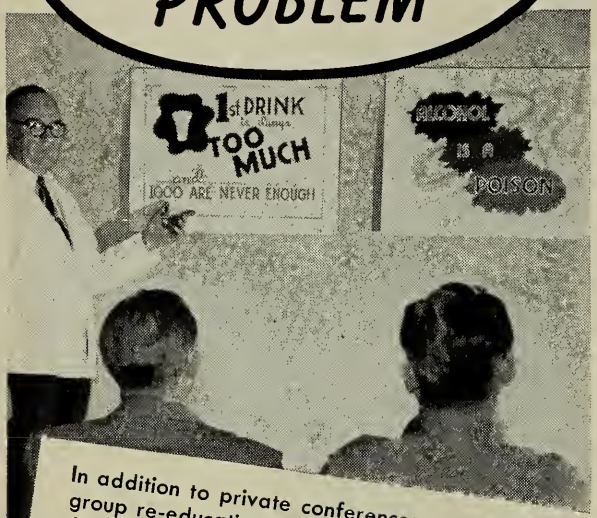
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FOREIGN QUARANTINE

There was a lag of nearly half a century in the conceptions of many countries on how to deal with matters concerned with foreign quarantine. Turning back the clock merely a quarter of a century places us in the days when there were neither antibiotics nor cheap, powerful insecticides. There was no yellow fever vaccine then and Soper had not yet discovered jungle yellow fever. Plague-infested vessels were commonplace. Cholera, typhus, and smallpox had recently made dramatic raids in Europe. In short, only yesterday, half the official world was acting as if it were living among the shadows of a remote past, undisturbed by the droning of airliners in the skies, unaware of the magic of preventive medicine, afraid of ghosts long laid. The need for uniform quarantine rules had been recognized for a century. The first international sanitary conference met in Paris in 1851. Subsequent conferences were held in capitals ranging geographically from Washington in the west to Constantinople in the east. Because of lack of knowledge concerning transmission of epidemic disease, the conferences accomplished for the ensuing 50 years little more than keeping the problem alive in the minds of the government departments concerned. The seaborne plague pandemic, which reached all continents except Australia around the turn of the century, greatly strengthened interest in standardized quarantine measures. *Knud Stowman, Ph.D., International Sanitary Relations. Pub. Health Rep. Oct.* 1952.

The fact that there are at all times a large number of unknown cases indicates the necessity for continuing the efforts to screen out the cases of tuberculosis. Arthur C. Christie, M.D., J.A.M.A., January 10, 1953.

Our community-wide barriers against disease, applying to large groups rather than only to individuals and not possible except through organized action, are: physical—filtration of water, pasteurization of milk, improved housing, and air pollution control; physiological—widespread immunization programs, better nutrition, and fluoridation of water supplies; epidemiological—isolation, quarantine, vector eradication, and early case control; and educational—accident prevention, heart disease, and cancer information leading to prevention or early recognition, and promotion of health habits leading to a high level of total physical, emotional, and mental efficiency. Berwyn F. Mattison, M.D., American J. of Public Health, December, 1952.



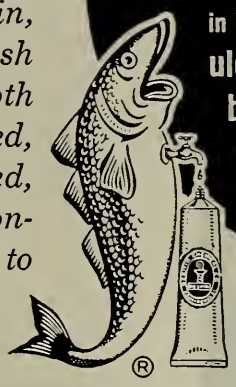
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2. Turell, R.: New York St. J. M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives Pediat. 68:382, 1951.



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QUOTING OUT OF CONTEXT

A Lincoln newspaper recently published a contribution by Arthur J. Snider, "Lincoln Journal-Chicago Daily News Science Writer." Mr. Snider reviewed an article, "Medical Problems Created by a National Blood Program" by Carl V. Moore, M.D., later published in the Journal of the American Medical Association (149:1603, Aug. 30, 1952). The review consisted of about half a column but under a four column headline in large, boldfaced type, which stated "Blood Transfusions as 'Tonic' Causing Deaths." Mr. Snider selected a very small part of Dr. Moore's dissertation on transfusions; just that portion which, if headlined correctly, would serve more to frighten than enlighten the readers. Furthermore, neither the headline nor the review itself reflected the true sense of Dr. Moore's paper. When the writer quoted directly, the quotation being out of context did not carry precisely the meaning which Dr. Moore intended. Like some other science writers' columns which one may readily find, this is not news, in the strict sense of the word. What, one asks himself, is the object of this type of writing about medical science. Is it to embarrass the doctor? Is it purposely to frighten and mislead the public? Or is it merely to meet an assignment for which the writer gets paid? *Editorial, Science Writing. Nebraska M.J. Oct.* 1952.

EXORBITANT FEES

Another trend in medicine which is to be greatly deplored is the charging of exorbitant fees by certain people. Some of these high chargers are young men who feel that they must get money and are not willing to take the risk of robbing a bank. Because the cost of living is very much higher and the dollar is worth very much less, it seems that doctors going into practice now are joining in with everybody else in the endeavor to get all the money possible in the shortest time possible. The situation is such as to bring to mind the terrible condemnation of the Psalmist, "They are altogether becoming filthy." *Claude C. Coleman, M.D., Some Observations On The Practice Of Medicine. South. Med. & Surg. Oct.* 1952.

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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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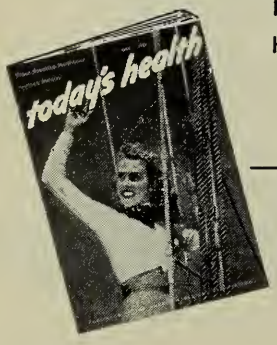
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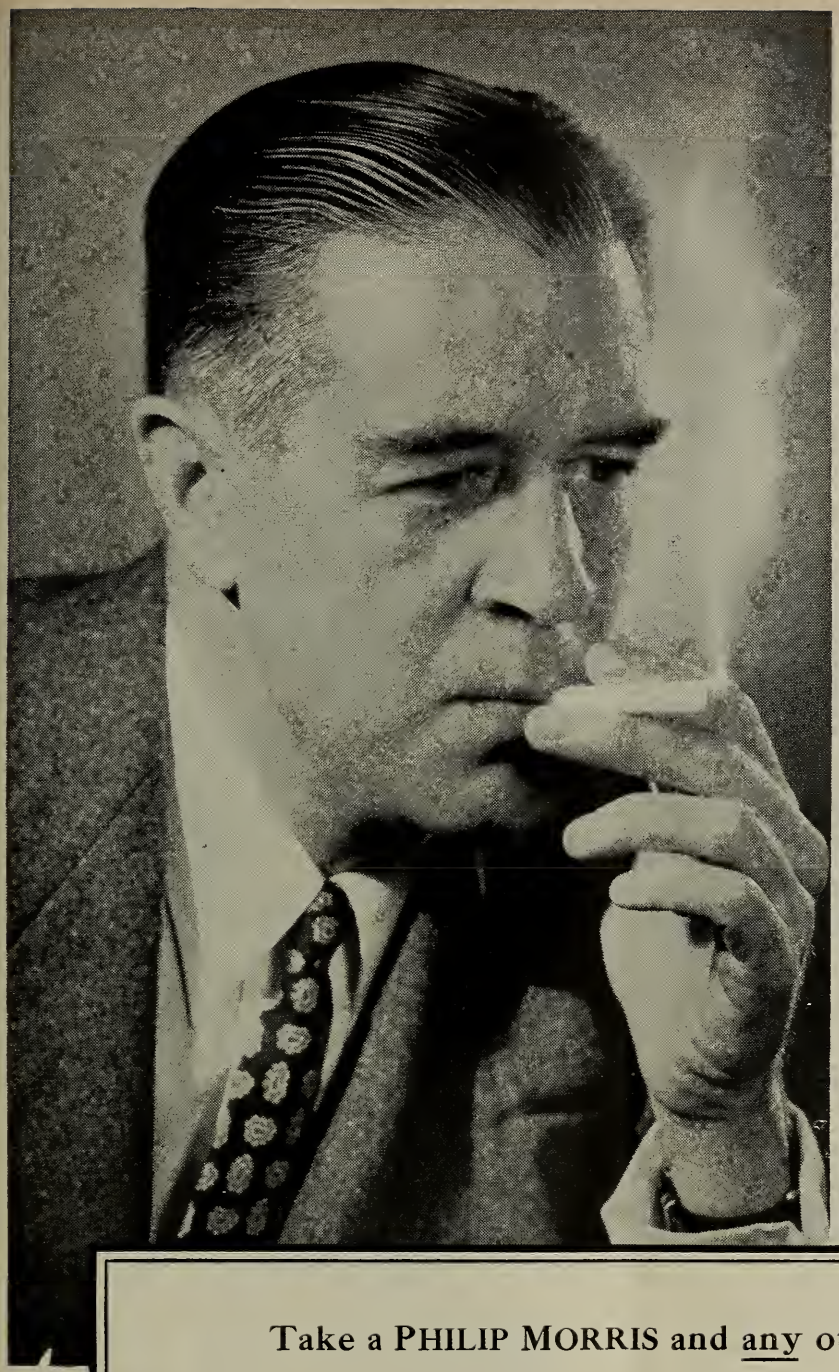
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RESPOND TO CALLS PROMPTLY

Regardless of the urgency of a professional call, the physician in responding thereto has no legal right in so doing, to violate any traffic or other law, or to thereby place in jeopardy the lives or safety of others. Not even ambulances have that right. When a physician receives a call, from the nature of which he would have reason to infer that the patient's best interests demand immediate response with dispatch, it becomes the physician's legal duty to respond as rapidly as he can without violating the law. Or, failing to be able to respond promptly he should refuse to agree to take the case. Leisure response when urgency is pleaded almost certainly implies justification for tort action. It is just as much a part of obligatory treatment the patient is entitled to when he desires his pains relieved, as it is necessary to treat the disease or injury which causes the pain. Competent medical services include, whenever possible, the duty of making the patient comfortable, either physically or mentally or both. In a certain case the malpractice claimed was essentially based upon the fact that when the plaintiff's wife had informed the attending physician several times during the night that her husband was in intense pain and desired something done to relieve him, the physician delayed in responding to her calls for eight or nine hours. The court awarded damages for the suffering caused by the undue delay. *Bits of Information Which May Save A Doctor Embarrassment and Money. South. Med. & Surg. Aug.* 1952.

Tuberculosis is worldwide and relatively few countries have progressed so far as or beyond the United States in their schemes for its control. With the notable increase in international travel and especially in aviation and now the resettlement of displaced persons, protective immigration policies assume added importance. Kendall Emerson, M.D., Conn. State Med. J., May, 1952.

More field studies are needed to establish quantitative relationships between disease and social factors such as age, race, sex, occupation, and economic status. These factors and their impact on community disease patterns are our counterparts of the clinicians' measurement of pulse, blood pressure, basal metabolic rate, etc., in the individual. They, and their relationship to disease and health deserve more attention than we have afforded them. Berwyn F. Mattison, M.D., American J. of Pub. Health, Dec., 1952.



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H. J. Carr, M.D., Staff Physician.

BOOK REVIEWS (Continued)

very practical and well worth a place in the library of any practicing physician.

The only section, which would prove of little value to physicians in the United States, is the section on Medico-Legal Emergencies. This section is based on British Medical-Jurisprudence and therefore not completely applicable.

J. W. P.

HANDBOOK OF ORTHOPAEDIC SURGERY. By Alfred Rives Shands, Jr., B.A., M.D. In collaboration with Richard Beverly Raney, B.A., M.D. Illustrated by Jack Bonacker Wilson and others. Fourth edition. Published by The C. V. Mosby Company, St. Louis. Copyright 1952. Price $8.00.

This work has become a standard in the training of medical students and orthopaedic residents since the publication of the first edition in 1937.

This latest edition presents many changes, which greatly enhance its value. New material has been added, as for example, in the section dealing with the foot of the normal child. There are 106 new illustrations, which make for greater clarity of presentation with economy of explanatory text. The bibliography has been revised to March 1, 1952.

J. W. P.

DISEASES OF THE SKIN. First compiled by the late Robert W. MacKenna, M.A., M.D., Ch.B. (Edin.). Fifth edition by Robert M. B. MacKenna, M.A., M.D. (Camb.), F.R.C.P. (Lond.). With a chapter concerning radiology. By I. G. Williams, F.R.C.S. (Eng.), D.M.R.E. (Camb.), F.F.R. (Gt.B.). Published by The Williams & Wilkins Co., Baltimore. Copyright 1952. Price $8.00.

A British import designed primarily for students, but also of value to the general practitioner.

The arrangement of the subject matter is typical and satisfactory. The type and paper are excellent. The black and white photographs and illustrations are good, but the color plates are poor.

The author's use of some of the latest therapeutic drugs, such as ACTH and cortisone, is extremely conservative. There is no bibliography.

J. W. P.

OPERATIVE GYNECOLOGY. By Richard W. Te Linde, Professor of Gynecology, Johns Hopkins University and Chief Gynecologist, Johns Hopkins Hospital. 409 figures and 7 color plates. Second edition. Published by J. B. Lippincott Company, East Washington Square, Philadelphia, Pa. Copyright 1953.

A very favorable new edition of this most comprehensive and detailed text on surgical gynecology. There are many new illustrations and a revision of certain sections, which keep pace with the latest de-

(*Continued on page* 60)

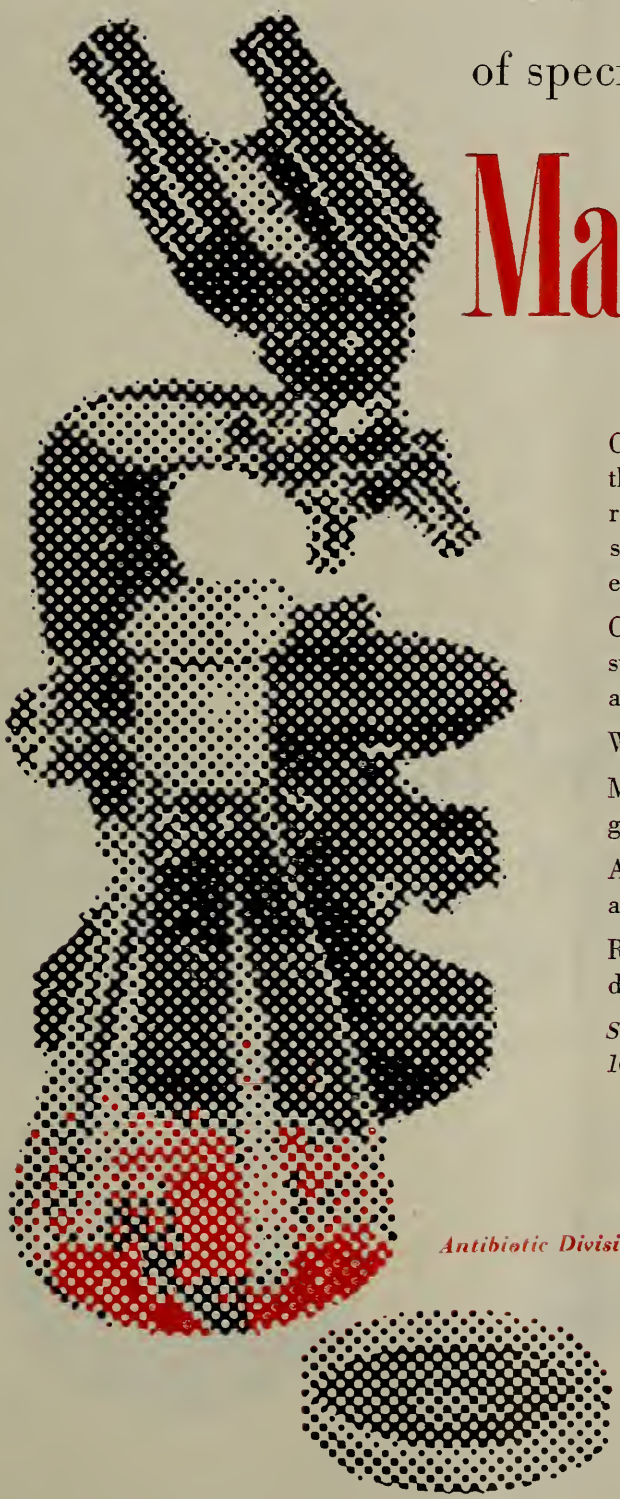
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BOOK REVIEWS (Continued)

velopments in the field. The section on Culdoscopy is an example in point.

The entire text is profusely illustrated with fine anatomical drawings, photographs of x-ray films, and seven color plates. Each chapter carries a carefully selected bibliography.

J. W. P.

POLIOMYELITIS. Compiled and edited for the International Poliomyelitis Congress. Published by J. B. Lippincott Company, East Washington Square, Philadelphia, Pa. Copyright 1952. Price $7.50.

This book is a collection of the papers and discussions presented at the Second International Poliomyelitis Conference held at the Medicinsk-Anatomisk Institut of the University of Copenhagen in 1952.

Although the text is limited in its audience, because of subject matter, the range of papers covers almost every field of medical and surgical endeavor.

J. W. P.

CLINICAL OBSTETRICS. By members of the Staff of the Pennsylvania Hospital. Edited by Clifford B. Lull, M.D., Late Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital; and Robert A. Kimbrough, M.D., Director of the Division of Obstetrics and Gynecology, Pennsylvania Hospital;



Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Gynecologist to the Graduate Hospital.

This work records current methods of management of the pregnant woman in the Pennsylvania Hospital in Philadelphia. Therefore it is a record of practice rather than an encyclopedia of Obstetrics.

Organization of the book is different from the usual in that, although following somewhat a chronological scheme many and unique deviations are made. Subjects are dealt with in their entirety in one chapter rather than scattering them piecemeal throughout the text. For instance clinical laboratory tests applicable to both normal and abnormal pregnancy are collected in one chapter. The same is true for the detailed discussion of Pathology.

Hemorrhages of pregnancy and labor puerperium are grouped in one portion. When used as a "reference" the above mentioned grouping is a valuable asset for speeding up study of references.

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(*Continued on page 62*)

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of quieting the apprehensions of a prospective mother's family.

Toxemias are of course considered and in detail. Attempt is made and with considerable justification on the nutritional aspect as a possible means of preventing or alleviating toxemia. This, although not new is certainly dealt with in a rational manner.

Fertility and "Infertility" is considered in this volume rather than "Sterility". Emphasis is placed on complete, very complete and very careful physical examination and the use of laboratory procedures in making decisions as to infertility. The value of endocrines of course, is given adequate space and worthy consideration. Very definite technique is given for correction of infertility, definitely and very lucidly.

The various maneuvers necessary for successful accomplishment of births are excellently handled. Diagrams are used to illustrate the text which elucidates the procedures very greatly.

Very few cuts of microscopic sections are shown and this of course is to the author's credit.

The index is very complete and makes the content of the volume easily accessible.

A volume of more than ordinary value in any one's library.

C. P. B.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will glady furnish same promptly.

INFLUENZA and Other Virus Infections of the Respiratory Tract. By C. H. Stuart-Harris, M.D., F.R.C.P., Professor of Medicine, University of Sheffield. With a foreword by C. R. Andrewes, M.D., F.R.C.P., F.R.S., Deputy Director, National Institute for Medical Research. Edward Arnold & Co., Publishers, London. $6.00.

DISEASES OF CHILDREN. Fifth Edition. Edited by Alan Moncrieff, C.B.E., M.D., F.R.C.P., Nuffeld, Professor of Child Health, University of London; Physician, The Hospital for Sick Children, Great Ormond Street; Consulting Physician, Children's Department, Middlesex Hospital, and Philip Evans, M.D., M. Sc., F.R.C.P., Physician to the Children's Department and Director of the Department of Child Health, Guy's Hospital; Physician, The Hospital for Sick Children, Great Ormond Street. With contributions by 50 contributors. Two volumes. Edward Arnold & Co., Publishers, London. $21.00.

(*Continued on page* 64)

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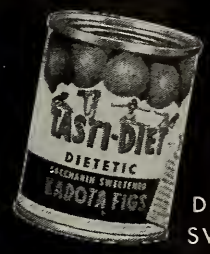
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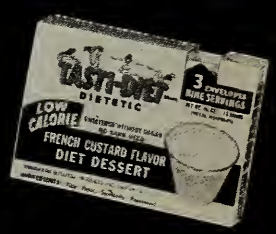
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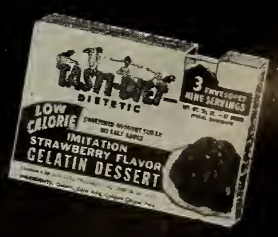
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BOOKS RECEIVED (Continued)

A Modern Practice of Obstetrics. By D. M. Stern, M.A., M.B., B.Ch. (Cantab.), F.R.C.S., F.R.C.O.G. and C. W. F. Burnett, M.D. (Lond.) F.R.C.S., F.R.C.O.G. Line drawings by Susan M. Robinson, Bailliere, Tindall and Cox, Publishers, 7 and Henrietta Street, W. C. 2, London. $7.00.

Contact Dermatitis. By George L. Waldbott, M.D., F.A.A.A., F.A.C.A., F.I.A.A., F.A.C.P., Senior Physician, Harper Hospital, Chief of Division of Allergy, Assistant Physician, Grace Hospital, Chief of Allergy Clinic, Formerly, Director of Allergy Clinic, Children's Hospital of Michigan, Formerly, Consultant Allergist, St Mary's Hospital and North End Clinic, Detroit, Michigan. Charles C. Thomas, Publisher, Springfield, Illinois.

Clinical Diagnosis by Laboratory Methods. A Working Manual of Clinical Pathology: By James Campbell Todd, Ph.B., M.D., Late Professor of Clinical Pathology, University of Colorado School of Medicine; Arthur Hawley Sanford, A.M., M.D., Emeritus Professor of Clinical Pathology, The Mayo Foundation, University of Minnesota; Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, Department of Medicine, University of Arkansas School of Medicine. New. 12th Edition. 998 pages with 946 illustrations, 197 in color, on 43 figures. Philadelphia and London: W. B. Saunders Company, 1953. $8.50.

Children of Divorce. By J. Louise Despert, M.D., Doubleday & Company, Inc., Garden City, N. Y. $3.50.

Dermatology in General Practice. Clinical picture, differential diagnosis, and specific treatment of all the common skin diseases. By Jacob Hyams Swartz, M.D., Assistant Professor of Dermatology, Harvard Medical School and Postgraduate School; Consulting Dermatologist, Massachusetts General Hospital; Member American Dermatological Association, American Mycological Association; Diplomate American Board of Dermatology. Foreword by C. Guy Lane, M.D., Professor Emeritus, Department of Dermatology, Harvard Medical School; Consulting Dermatologist, Massachusetts General Hospital. The Williams & Wilkins Company, Baltimore. $11.00.

Clinical Cardiology. Edited by Franklin C. Massey, A.B., M.D., Assistant Professor of Medicine, Hahnemann Medical College, Philadelphia, Pennsylvania. The Williams & Wilkins Company, Baltimore, Maryland. $13.50.

The Physical Examination of the Surgical Patient. By J. Englebert Dunphy, M.D., F.A.C.S., Associate Clinical Professor of Surgery, Harvard Medical School; and Thomas W. Botsford, M.D., F.A.C.S., Clinical Associate in Surgery, Harvard Medical School; 326 pages with 188 figures. Phila-

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delphia and London: W. B. Saunders Company, 1953. Price $7.50.

AN ATLAS OF SURGICAL EXPOSURES OF THE EXTREMITIES: By Sam W. Banks, M.D., Associate Professor of Orthopedic Surgery, Northwestern University Medical School; and Harold Laufman, M.D., Ph.D., Associate Professor of Surgery and Director of Experimental Surgery, Northwestern University Medical School; 391 pages with 552 illustrations on 179 plates. Philadelphia and London: W. B. Saunders Company. $15.00.

DISEASES OF THE DIGESTIVE SYSTEM. Edited by Sidney A. Portis, B.S., M.D., F.A.C.P., Associate Clinical Professor of Medicine, University of Illinois Medical School; Senior Attending Physician in the Department of Medicine, Michael Reese Hospital; Consulting Physician, Cook County Hospital; Member of Advisory Board of Institute of Psychoanalysis; Chief of the Medical Services of the Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital, Chicago, Ill. Third

MODERN TREATMENT, A Guide for General Practice. By 53 authors. Edited by Austin Smith, M.D., Editor of the Journal of the American Medical Association and Paul L. Wermer, M.D., Secretary, Committee on Research, American Medical Association. Paul B. Hoeber, Inc. Publishers, Medical Book Department of Harper & Brothers, New York. $20.00.

OVEREATING, OVERWEIGHT AND OBESITY, Proceedings of the Nutrition Symposium held at the Harvard School of Public Health, Boston, Massachusetts, October 29, 1952. David P. Barr, John R. Brobeck, Henry W. Brosin, Louis I. Dublin, Frank A. Evans, P. C. Fry, Samuel Gurin, Paul Gyorgy, Edward E. Hunt, Jr., Ancel Keys, P. S. Peckos and A. W. Pennington. 1953. The National Vitamin Foundation, Incorporated, 150 Broadway, New York 38, New York. $1.50.

THE COOK BOOK FOR LOW SODIUM DIET. By Reena Roberts Hasker, B.S., M.A., Published by The Massachusetts Heart Association, Inc., 500 Commonwealth Avenue, Boston, Mass. Distributed by Illinois Department of Public Health.

THE RURAL CONGREGATION AND COMMUNITY HEALTH. Printed by The R. C. Tune Company, Chicago. Prepared by Division of American Missions, National Lutheran Council, 327 South LaSalle Street, Chicago 4, Illinois, 1953. Copies 50c each; 10 or more 35c each; 100 or more 25c each.

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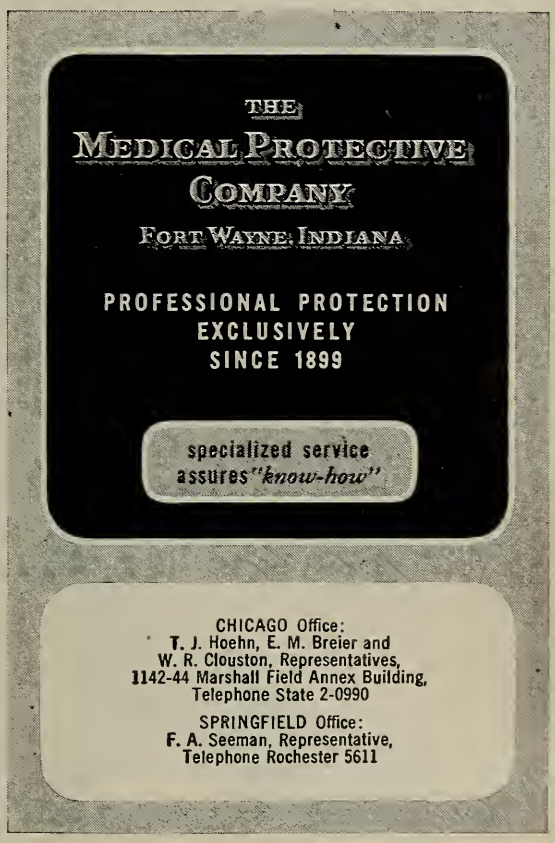
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either a state of unwarranted jubilation or depression, depending upon the slight variation of the point reading. It is most important at this time to explain to the patient the really excellent prognosis of the disease if he will follow a few simple measures. *Thomas F. Frist, M.D., Medical Treatment Of Hypertension. J. Tennessee M.A. Dec.* 1952.

Streptomycin and PAS are not bacteriocidal but bacteriostatic. They do not cure or eradicate the disease. Relapses occur and reconversion of sputum from negative to positive is frequent. They have markedly improved the prognosis of tuberculosis but have not controlled it. John H. Skavlem, M.D., The W. Va. Med. J., December, 1952.

Many physicians are reluctant to believe that people can have pulmonary tuberculosis when they show no clinical symptoms and there is nothing to direct attention to their lungs except a shadow on a chest film. The tendency is to reassure the patient that the lesions are old and inactive, but the tragedy comes later when the same patient is found to have moderately or far advanced disease. Alan L. Hart, M.D., Public Health Reports, December, 1952.



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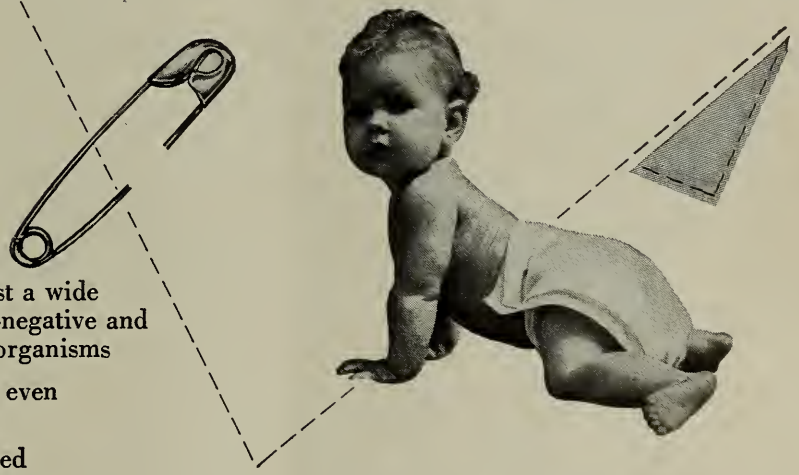
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OVERSPECIALIZATION

Every scientist feels acutely today the effects of overspecialization We are told that long ago there was a strange sort of real estate development. My memory of what I learned about it in my youth is somewhat hazy. But it seems that there was a project to construct some sort of Empire State Building, only much larger and more grandiose, reaching up toward the sky and mingling with the clouds. It was called the Tower of Babel. As the story goes, it was never completed, for the plans ended in confusion. The workmen suddenly found that each one was speaking a special language and that no man understood what the other was saying. So the minor construction went on piece by piece, but none of the pieces fitted; and the general plan of construction was completely lost. We are in danger, in science, of building a Tower of Babel. This is especially true in the science that deals with man. *Vannevar Bush, D. Eng., Sc.D., "We Are In Danger Of Building A Tower Of Babel." Pub. Health Rep., Feb. 1953.*

Because of wider and broader education people have learned the value of modern medicine in relieving and preventing sickness. New health attitudes are resulting from intelligent health education. Hugh R. Leavell, M.D., The New Eng. J. of Med., Dec. 4, 1952.

LICENSING PHYSIOTHERAPISTS

The relationship between the physician and the physical therapist is comparable to that of the physician and the pharmacist in prescribing and dispensing drugs. (Physical agents should be considered as drugs used externally.) The doctor does not have to know how to compound medicines; he tells the pharmacist what he desires. Having confidence in the pharmacist performing the technical work, the doctor knows that if there is ambiguity in his prescription, it will be called to his attention. The same relationship exists between the physician and a qualified physical therapist.

For the protection of the sick or injured, this relationship should be legalized, permitting only well qualified persons to be licensed for this purpose. Prescribing physicians should demand this for their own protection as the final responsibility for treatment rests on the prescribing physician. Only when the physical therapist is licensed by the state will the referring physician know and be assured that his patient will receive the desired treatment in accordance with his prescription and accompanied by all appropriate safeguards. Licensing of physical therapists will assure adequate training and will encourage high standards. Of course, it will hurt some persons, especially the irregular practitioners who claim "wonder cures" by physical agents without adequate basis. Licensing of physical therapists would eliminate such assertions. *Odon F. von Werssowetz, M.D., J. Tennessee M.A., Dec. 1952.*

It is a matter of well authenticated experience that in both world wars, where large segments of the population of some countries usually offering adequate food supplies were insufficiently nourished, the incidence of and mortality from tuberculosis in such areas definitely increased. Possibly some of these patients suffered from primary infections, but no doubt in many of them reduced resistance led to reinfection or the reactivation of quiescent lesions. George Blumer, M.D., Conn. State Med. J., May, 1952.

The Illinois Medical Journal

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The Illinois State Medical Society

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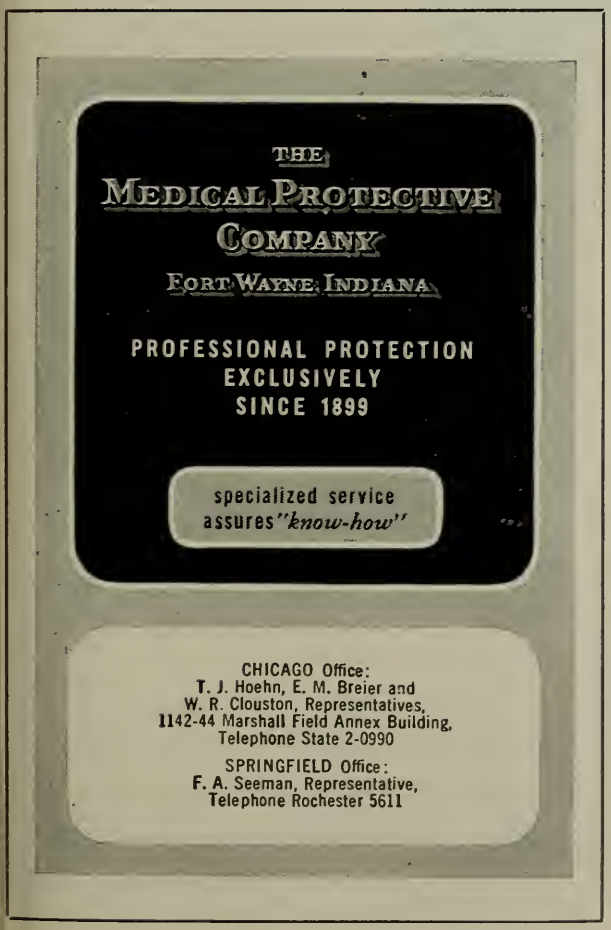
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The ILLINOIS Medical Journal

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Vol. 104, No. 1 July, 1953

The Obstetrician and Fetal Death

Hubert L. Allen, M.D.
Alton

Maternal mortality rates have gradually been reduced to satisfactory levels, but stillbirth and neonatal death rates have failed to decline commensurately. Recent statistics of the Metropolitan Life Insurance Company show a decided relative increase in infant deaths during the first 24-hours of life. The combined stillbirth and neonatal mortality rate in the United States is 5%, and represents a loss of over 150,000 lives annually. In 1949, one out of 20 pregnant women failed to produce a living child[1].

We cannot prevent deaths of previable or hopelessly malformed infants, and these will not be considered here. However, there are certain cases in which survival of the infant depends upon obstetrical judgment and management. Some of the obstetrical factors involved in fetal survival may be discussed in general terms, being applicable to all cases. Among these are: analgesia and anesthesia during labor and delivery, and resuscitation of the apneic infant. Other factors more specific are: management of placental and cord abnormalities; consideration of the baby of the pregnant diabetic; and management of breech presentation. There are, of course, many more subjects which could properly be discussed, but it is the purpose of this paper to review the management of a few conditions which, in our experience, seem to lead most frequently to preventable infant deaths. Obstetrical services should not be judged merely on the basis of maternal mortality and morbidity. Sometimes " our errors are reflected in not obtaining a living child, while such errors are not of an order to produce maternal death or morbidity".[2]

Analgesia and Anesthesia:— We all know that the perfect obstetric analgesic agent has not yet been developed. Numerous drugs and combinations of drugs are used to provide some relief from the pain of labor. Obstetricians have their individual perferences, and, like the choice of forceps, one chould decide which combination works best for him and stick to it, with variations determined by the individual requirements of his patients. There are those who give no antepartum medication whatsoever, but most of us attempt to provide some analgesia for the parturient woman within the limits of safety for her and for the baby. It is rarely wise to have a "routine" of medication to be administered at the discretion of a nurse. Individual tolerance to drugs is widely variable, and a nurse's judgment as to the progress of labor may or may not be accurate. It is beyond the scope of this paper to discuss the various analgesic agents in obstetrics, but in general it may be said that the smallest amount of medication to accomplish the desired relief of pain should be employed. In selecting obstetric analgesic drugs, it is well to bear in mind that too early administration or too large dosages can result in serious disturbance in the physiology of labor. We have all seen the flushed, disoriented, dehydrated parturient who has been overly "twilighted" in an effort to spare her the pain

Presented before the General Assembly, 112th Annual Meeting, Illinois State Medical Society, May 14, 1952.

of labor. This patient may have a much longer labor than she would have had with more judicious doses and she may also give birth to an apnoeic, cyanotic infant.

Obstetrical anesthesia is today one of the gravest problems in hospital practice. According to Dr. Newberger,[3] of 290 maternal deaths in the State of Illinois outside Chicago, 14 were attributed to anesthesia. When one considers how obstetrical anesthetics are administered in some of our institutions, it is surprising that the figure is not larger. It is certain that many infant deaths are directly ascribable to this cause. In general, hospital budgets do not permit the hiring of qualified anesthetists for the obstetric departments. Nurse anesthetists refuse employment in institutions which requires them to serve the delivery rooms unless there are sufficient anestetists available to provide proper relief. This is understandable, and a girl cannot be expected to render efficient service in the operating room all morning and part of the afternoon and then be up all night in the maternity division. Also, the current shortage of registered nurse anesthetists has created such a demand for them that they are extremely independent and can be very selective in accepting jobs. At the same time, the public has been educated to believe in hospital maternity care, and in this state, well over 90% of confinements occur in hospitals. Some form of anesthesia is expected, and the patients receive it and are charged for it. Very often the anesthetic is administered by an unqualified individual who has no idea of the seriousness of her duty. Fortunately, most of the anesthetics are of brief duration, requiring only superficial anesthesia; but occasions arise, as all of us know, when deeper planes of anesthesia over longer durations are required.

I have no solution to this problem, but I think it should be emphasized that the patient is the responsibility of the physician and it is his job to minimize the risk inherent in these unfortunate circumstances to the best of his ability. The use of local anesthesia is helpful and the technique easy to learn. Results are excellent, especially when a mixture of procaine, hyaluronidase and adrenalin is employed.[4] Avoidance of deep general anesthesia is of utmost importance if we are to deliver healthy infants. From the point of view of the baby, various types of conduction anesthetics are a boon — especially in the case of premature infants. However, these methods carry definite hazards for the mother which must be recognized and evaluated.

Regardless of the management of labor and delivery, fetal apnoea will be encountered in the occasional case. Factors contributing to its development are:

1) Analgesia and anesthesia administered to the mother.
2) Interference with fetal circulation in utero, such as that due to placenta previa, abruptio, vasa previa, compression of the umbilical cord through torsion, knotting or prolapse.
3) Prolonged difficult labor.
4) Operative delivery.

Resuscitation is an art and the days are gone of "acrobatic" resuscitation, with its swinging and beating of babies, ice-cold baths and other traumatic procedures designed to shock the newborn into vigorous respiratory efforts. Better understanding of the physiology of the newborn has led to more gentle manipulations aimed at:

1) clearing the airway,
2) providing a source of oxygen, and
3) maintaining normal body temperature.

Anyone who delivers babies should be skilled in the use of the tracheal catheter. It matters little whether this valuable instrument is introduced by touch or under direct vision by the use of the infant laryngoscope. The tracheal catheter is a life-saver when properly utilized; in certain cases, there is no substitute for it. Babies have been lost because it has not been employed, or has been used too late to accomplish establishment of a clear airway. Mechanical resuscitators are available in most delivery rooms, and while they have their uses, they are of little value in the case of the apnoeic infant whose trachea is mechanically blocked. Training in obstetrics should include special instruction in tracheal intubation. Stillborn infants should be used for practice in this technique. Despite the introduction of complex airlocks and other devices for resuscitation of the new-born, the individual skill of the physician

(*Continued on page* 4)

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must remain the determining factor in the life or death of certain newborn infants.

Premature Labor:— First, it is important to avoid premature labor by educating patients to report suspicious symptoms so that restriction of activity, sedation and hormone therapy may be instituted. In the event that labor continues, certain fundamental precautions must be used if these babies are to survive. Administration of vitamin "K" to the mother, avoidance of analgesia except in very small doses, liberal use of outlet forceps and episiotomy and avoidance of general anesthesia are some of these basic factors. Masters, in an excellent report from St. Louis Maternity Hospital,[5] clearly demonstrated a lowered premature mortality rate in cases delivered with caudal anesthesia in contrast with those which received inhalation anesthesia. Similarly good results in premature salvage can be obtained by other conduction anesthesia or with local and pudendal block. Once the premature infant is delivered, it is important to protect it by avoiding exposure and chilling. Extreme gentleness must be employed in handling the infant and it should be handled as little as possible, but should be placed imediately in a previously prepared incubator, where such things as instillation of medication into the eyes, tying the cord and applying the identification bracelet may later be performed. Expert pediatric consultation should be the rule. Many hospitals have adopted the regulation that all babies weighing 2500 grams or less must be managed by qualified pediatricians. This has led to some resentment, but most physicians have been glad to turn these infants over to consultants. There is everything to gain and nothing to lose by so doing. Even the most skillful pediatrician will have a high premature death rate if the nursing service in the newborn nursery is inadequate. Most of our general hospitals are understaffed and it is not always possible to have even one graduate nurse assigned to the nursery on every eight-hour shift. Therefore, nurses' aides are called upon to assume full charge, and while many of these women do excellent work and are thoroughly conscientious, they are not well trained, and it is not to be expected that they can always recognize premonitory signals of impending tragedy in time to alert the physician.

One of the finest projects ever undertaken by the State Department of Public Health was the creation of the Premature Centers. The realization has developed that care of the premature infant is a highly specialized, institutional problem, depending for the most part upon excellent nursing care. It has come to be accepted as a legitimate public health problem just as tuberculosis, psychosis, narcotic addiction, etc.

The obstetrician's role in premature care is a highly important one. He must avoid narcotizing the mother, either with analgesic antepartum drugs or with deep general anesthesia during delivery. His best judgment is called upon to prevent undue protraction of the 2nd stage of labor while not interfering too soon. His handling of the new-born infant may be the determining factor in borderline cases, and he must be ready and willing to share the responsibility with the pediatrician.

Placenta Previa and Premature Separation:— Inasmuch as we are concerned here chiefly with fetal salvage, these conditions can well be considered together. The mechanism which threatens the infant is deprivation of its blood supply and such deprivation is accomplished by partial detachment of the placenta in both conditions.

Babies have been lost by overconservative attitudes toward Cesarean section. Not infrequently a patient 35 or 36 weeks pregnant, upon developing an early abruption or previa will be handled expectantly, in the hope that she will ultimately fall into labor and deliver vaginally. Maternal blood loss can usually be replaced, but we cannot reestablish the uteroplacental relationship upon which the fetus must depend. I am not advocating routine section of all patients with viable infants who develop placenta previa or abruptio; many of them will deliver vaginally and have living infants. But it is perhaps fair to say that many a baby could be salvaged by a timely section, which is finally lost through misguided attempts at vaginal delivery or a cesarean too long deferred.

There is a very important contrasting side of this picture. During the past ten years, the fetal survival rate in placenta previa has improved considerably, due largely to the wider

application of "expectant treatment". This yields good results where the patient is far from term or when the infant is not considered viable by estimated weight. Prolonged hospitalization and careful observation are required. "When frequency or severity of hemorrhage is such as to preclude further expectancy, the pregnancy is terminated."[6]

The Pregnant Diabetic:— Volumes have been written on the subject of the pregnant diabetic, and it is our purpose to deal only with that phase of the problem which concerns the survival of the baby. The wise obstetrician will always enlist the aid of a competent internist when caring for one of these patients. The consultant will have his hands full stabilizing the metabolism and the obstetrician will be equally occupied in averting toxemias and in dealing with the placental abnormalities so frequently encountered in this group of patients. It is a well-known fact that severe diabetics are apt to have very large infants. In addition, these babies tend to die in utero as term is reached or approached. Because of this, diabetes mellitus is becoming a more frequent indication for cesarean section. Selecting the time for such an elective procedure calls for considerable judgment and a certain amount of luck. It is perfectly possible for a diabetic to give birth to a nine pound infant which is nevertheless premature, and vulnerable to all of the usual hazards of the premature infant. I certainly do not feel that all pregnant diabetics should be sectioned, but they must be observed carefully and frequently, especially as they near term, in order to decide whether or not interference will be required and, if so, whether that interference should be in the form of induction of labor or abdominal delivery. Even with most careful observation, it is easy to err; most of us have had the unpleasant experience of losing these babies near term or during the course of labor. Again in this condition, the pediatrician is an essential ally and should be notified well in advance of the metabolic condition of the mother so that he can map out a logical regime for management of the baby and its fluctuating sugar metabolism.

Breech Presentation:— While it is not my purpose to discuss all of the many obstetrical complications which endanger the baby, I was led to include a paragraph on this subject because of the fact that three babies have been lost within the past three months in our local hospitals, due to inability of the attendants to deliver the aftercoming heads.

The fact that mortality is so much higher in breech than in vertex presentations indicates that there is much to be learned about the management of this condition. While it is true that there is a higher incidence of premature rupture of membranes and prolapse of the cord, there are some of these babies who do not survive because of technical errors in management at the time of delivery. It is very important to make the diagnosis of breech presentation before the onset of labor, and this is especially true in the case of the patient with any degree of pelvic contracture. Other factors which must be carefully considered are the resistance of the pelvic musculature, the apparent size of the baby and the age of the patient. In a vertex presentation, the question of feto-pelvic disproportion may be resolved in borderline cases by a trial of labor. With the breech presenting, there can be no trial of labor, since the unmolded aftercoming head may present very great difficulty in delivery if disproportion actually exists, and the baby will be lost. Some of these unhappy results can be averted by recognizing breech presentation as a potential source of serious trouble and by making every attempt to evaluate pelvic capacity and fetal size with utmost accuracy.

It is not a stigma of radicalism to perform cesarean sections for the indication of breech presentation, providing that careful evaluation seems to cast doubt on feto-pelvic proportion.

I believe that the incidence of breech presentation can be reduced by performing external versions during prenatal visits. When this maneuver is successful, a certain number will revert to the breech lie, and in those cases which persist as vertex presentations, we cannot prove that version would not have occurred spontaneously. Nevertheless, it is my feeling that the procedure is worth while and should be practiced more widely.

SUMMARY AND CONCLUSIONS

Maternal mortality and morbidity statistics can no longer be considered fair criteria of the efficiency of an obstetrical service, since these

rates are approaching an irreducible minimum. Instead, closer attention should be given to stillbirth and neonatal death rates as an index of this efficiency.

Certain antepartum and postpartum infant deaths must be classed as preventable. Closer attention to basic obstetrical principles will lessen the number of these cases.

Several of these principles are discussed.

604 E. Broadway

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Rose Thorn Penetrating the Cornea Into Anterior Chamber

Thomas D. Allen, M.D. and E. A. Pushkin, M.D.
Evanston

The reasons we believe it wise to report this case of posterior rosette cataract from trauma are:—

1.-a small thorn penetrating the cornea can be a cause.
2.-we believe cortisone was not of great value.
3.-we desire to review the different explanations of the mechanism.

The patient, R. E. (#WA 976), was an 18 year old male seen on 12/26/50. While he was walking under a rose arbor, 48 hours previously, he experienced sudden pain in the right eye which soon subsided, but was followed by redness and photophobia.

His right vision was estimated at 20/30; there was slight photophobia and tearing and slight ciliary injection. In the cornea was an oblique tract, in the deeper part of which was the base of the thorn. The anterior chamber was of average depth, with no Tyndall nor cells. Most of the thorn was in the anterior chamber, from the tip of which a fibrinous band attached it to the iris. The pupil was 3mms. in diameter.

At 10 o'clock there was a small irregular sphincterotomy, across which two strands of iris bridged. There was no apparent anterior or posterior capsular damage. There were no vitreous opacities. In the fundus the nervehead was normal in color and outline with a physiologic cup. There was a tuft of medullated nerve fibers at 2 o'clock near the disc. The macula, periphery and vessels appeared to be normal.

The left vision and globe were perfectely normal, except for a small tuft of medullated nerve fibers at 6 to 7 o'clock near the disc.

The patient, being comfortable, and the eye showing such little re-action, it was decided to postpone surgery to the following morning. The pupil was dilated with atropine and 10% neosynephrine, and an attempt was made to remove the thorn trans-corneally. This failing, the thorn was then carefully pushed through the cornea; a scratch incision was made at 11 o'clock under a limbal flap and an iridectomy was done; the thorn was removed with forceps. Atropine and bichloride of mercury ointment was used and a monocular patch applied. Thirty-six hours later, on the first inspection, there was a 1 to 2 mm. hyphema, and the following day the anterior chamber was nearly filled with blood (manual trauma was suspected); three days later, nearly all of the blood was absorbed.

Two weeks following the injury a posterior subcapsular 8 petalled rosette-type cataract was observed, with a small localized anterior capsular opacity at 11 o'clock, but no perforation and no tract leading posteriorly to the lesion. Shreds

Presented before the Section on Eye, Ear, Nose and Throat, 111th Annual Meeting, Illinois State Medical Society, May 23, 1951.

of capsule or fibrin hung down on the lower pillar of the pupillary edge of the iris.

January 9th, 1951, he was put on cortisone suspension, 1 to 4, on empiric basis, one drop in the right eye every two hours; also atropine once a day. We wished to determine the influence, if any, of cortisone on the developing cataract. At this time, the vision in the right eye was 20/20−, with correction.

Three weeks later, the posterior subcapsular opacity appeared to be thinner, and seven weeks after injury, the right vision was correctable to 20/20, with a sphere +0.50, cylinder +2.25, axis 75. We feel that the effects of cortisone were negligible, inasmuch as other similar lesions, perhaps of smaller degree, have been reported as spontaneously resolving.

Hypothesis:— According to Bellows, Seraniden explained the development of this type of cataract as due to a luxation of the lens within the capsule, thus disturbing the insertion of the lens fibers into the posterior capsule. In this way, he explained the more frequent occurrences of posterior subcapsular, rather than anterior subcapsular lens changes, because the lens fibers insertions are prevented from reaching the anterior capsule by the intervening epithelium. Cattaneo referred to a transient posterior rosette subcapsular cataract as being due to the presence of fluid betweent the elements. He thought that in those cases no degenerative changes of the lens fibers occur and the lens fiber alterations are of such slight degree as to be reversible. Vogt believed that the suture system was the most vulnerable and after an injury changes occurred in this region. Peters and Angelucci and Pardo writing earlier, explained the formation of the lesion on a basis of disturbance of the vascular system which led to a temporary increase in the protein and crystalloid content of the aqueous, and thus disturbed the nutrition of the crystalline lens. Lo Cascio believed that the changes are due to osmotic changes. He stressed the fact that this balance is necessary for lenticular nutrition. Following trauma, this balance is disturbed and the epithelium is damaged, hence fluid from the aqueous enters the lens, thus producing the opacity.

According to Berliner, Vogt refers to the "throwing motion" of specifically heavy parts inside of the globe following contusion. He states that according to hydrodynamic laws, the contents of an eyeball being considered as fluid, the effect of the force is transferred not only in the direction of the blow, but with special intensity in all directions — "although a considerable amount of the force is dissipated when an actual perforation occurs, still a wave of high pressure may also set up further damage in parts not in direct line of force."

Wagenman states that when a localized injury to the anterior part of the lens occurs, fluid may very quickly make its way posteriorly by following the equatorial curve of the involved plane, so that an opacity remote from the injured site may occur.

The following is our conception of the sequence of events leading up to the formation of this type of cataract: immediately prior to the actual perforation of the globe by the thorn, a compression wave is produced by the corneal indentation. This compression wave displaces the lens zonular diaghragm, the greatest displacement being of the posterior pole of the lens. Stress is uniformly distributed between the posterior inserting zonular fibers and the posterior capsule. The increased intra-ocular pressure, however, is uniformly distributed throughout the inner and outer tunics of the globe. In the case at hand, the zonule and posterior capsule, both being strong in a young man, withstood the stretching as manifest by failure of the zonule to break, and the intactness of the posterior capsule. However, the posterior lens fibers just beneath the capsule and inserting into the posterior suture were damaged by this force. Local proteolytic changes resulted from this trauma, followed by imbibition of the locally existing interstitial fluid, and not aqueous through any particular route. (Our hypothesis differs from others, only in that respect.) If one accepts the above hypothesis, it is not necessary to consider that aqueous plays a role in the developement of this lesion.

DISCUSSION

Question: In accommodation is there not a stretching of the lens?

Dr. E. A. Pushkin, Chicago: In accommodation there is a bulging backward of the posterior surface of the lens at the expense of the diameter of the lens itself. It has to go somewhere. There is no suddenness about accomodation. Accommodation is a relatively gradual and passive process and it is dependent upon the plasticity of the lens itself. It is active only in

the cilcory body. Here we were dealing with a heavy substance, the lens, resting between aqueous and vitreous. As a result of the trauma, and this trauma is focal though the energy is disseminated in all directions, there is a sudden force which does not alter the anteroposterior diameter of the lens but which displaces the lens posteriorly completely. I think the kind of stretch put on the capsule is much greater than shown here in the pictures, which tend to minimize the extent. That is best demonstrated by the frequency of the dislocation of the lens where the zonular fibers actually give way and you have a defect in the suspensory ligament. I cannot very well compare those two except that there is considerable difference in the suddenness of the force and the mechanics are different in accommodation.

IMPROVING ON THE DICTIONARY

Committee—A group that keeps minutes but wastes hours.

Firmness—An admirable quality in ourselves that's regarded as pure stubborness in other people.

Hobby—Something you go goofy over to keep from going nuts over things in general.

Infant Prodigy—Small child with highly imaginative parents.

In-law—The one law you can't flout.

Joint Account—A bank account in which a husband deposits money and his wife draws it out.

Monologue—Conversation between husband and wife.

Parents—The hardships of a minor's life.

Philosophy—The system of being unhappy intelligently.

Advice—What a man gives when he gets too old to set a bad example.

Average Girl—One who thinks she is "above the average."

Gentleman—One who steps on his cigarette butt so it won't burn the carpet.

Intuition—Suspicion in skirts.

Neatness—The one good thing about being bald.

Secret—Something that is hushed about hither and yon.

Old Timer—One who remembers when a bureau was furniture.

Philosopher—A person who always knows what to do until it happens to him.

Parking Lot—A place where you leave your car to have dents made in the fenders.

Principles—Often prejudices, white-washed and surmounted by a neon halo.

Night Club—An ashtray with music.

Bulletin, Sangamon County Medical Society, June, 1953.

ARE YOU "AVERAGE," DOCTOR?

Take a look at the average Doctor if you think he is a quiet sort of an animal.

Every 14 hours, if you are an average physician, weighing about 175 lbs., this is what your achievements are (if you still expect to stay alive):

Your heart beats 103,689 times.
Your blood travels 168,000,000 miles.
You breathe 23,040 times.
You inhale 438 cubic feet of air.
You eat 3¼ pounds of food.
You drink 2.9 pounds of liquids.
You lose in weight 7.8 pounds of waste.
You perspire 1.43 pints.
You give off 2.6 degrees Fahrenheit.
You turn in your sleep 25 to 35 times.
You speak 4,800 words.
You move 750 major muscles.
Your nails grow .000046 of an inch.
Your hair grows .0174414 of an inch.
You exercise 7,000,000 brain cells.

—Bulletin of Middlesex County Medical Society.

EDITORIALS

THE 1953 ANNUAL MEETING

The 1953 annual meeting of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, May 19-22. Three half-days were devoted to meetings of the 12 scientific sections, and the remaining five half-days were devoted to General Assemblies with all sections participating. An excellent program was arranged and carried out as planned.

The House of Delegates held three meetings. The first session was held as usual on Tuesday afternoon. All day Wednesday was devoted to meetings of the reference committees, then a session of the House was held on Thursday afternoon and the final meeting on Friday morning. With the extra session of the House, the last meeting was shortened considerably and the arrangement was approved heartily by members of the House.

All reference committees held meetings, several of which lasted most of the day as many members desired to discuss resolutions and other matters of imporance referred to the respective committee groups.

The President of the Society, Dr. Leo P. A. Sweeney, officiated at the meetings of the House of Delegates in a most commendable manner. There were a number of highly controversial matters presented to the House, and every delegate was given the opportunity to express his opinion, then action was taken by the House as a whole.

There were the usual number of technical and scientific exhibits. Every effort was made to favor these exhibitors throughout the entire session. It was noted that there were fewer complaints registered at this meeting by exhibitors than at previous sessions in recent years.

At the last meeting of the House of Delegates, Willis I. Lewis of Herrin was inducted into the office of President by the retiring President, Leo P. A. Sweeney. Arkell M. Vaughn was elected as President-Elect; F. M. Nicholson of Chicago as First Vice-President; George E. Kirby of Spring Valley as Second Vice-President for the second term in that ofice; and Harold M. Camp of Monmouth was re-elected as Secretary-Treasurer. Members of the Council were elected as follows:

1st District—Joseph S. Lundholm of Rockford

2nd District—Joseph T. O'Neill, of Ottawa

3rd District—F. Lee Stone, Chicago
E. A. Piszczek of Chicago
George A. Hellmuth, Chicago
for the unexpired term of A. M. Vaughn

11th District—Edwin S. Hamilton of Kankakee

The registration at the 1953 annual meeting was as follows:

Physicians	1,833
Students	465
Guests	466
Auxiliary	309
Technical exhibitors	491
	3,664

The interest being shown by the medical students and by members of the Student American Association is growing. All five medical schools in the Chicago area now have chapters of the SAMA, and these young physicians are learning the problems or organization as they study medicine. They are a most welcome addition to our meeting, at the scientific sessions, to attend the scientific and technical exhibits, and to listen to the problems as discussed in our House of Delegates.

The registration of physicians at the 1953 meeting dropped from 2,109 in 1952 to 1,833 this year. As soon as possible we will check the registration cards to see wherein the lack of interest lay. The annual meeting of the state society offers scientific programs, scientific exhibits, scientific movies, an active four days of society legislative procedure (with the House meeting on three days, and the reference committees on the open day between sessions). The business affairs of the Illinois State Medical Society affect each member. The interest in annual meetings should be sustained and growing; suggestions for improving our meetings to make them more attracting to the membership would be most welcome. While the annual session is fresh in your mind, we would appreciate hearing from you. The meetings of your society can be improved through your participation and contribution, your assistance and counsel. We assure you of our desire to cooperate to make future meetings more and more successful.

ROUNDUP STORY ON AMERICAN MEDICAL ASSOCIATION'S ANNUAL MEETING IN NEW YORK CITY

The House of Delegates of the American Medical Association, in session at the Waldorf-Astoria Hotel during the 102nd Annual Meeting of the A.M.A. in New York City, took important policy sessions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

The House also named Dr. Walter B. Martin of Norfolk, Virginia, as president-elect of the American Medical Association for the coming year. Dr. Martin will become president at the June, 1954 meeting in San Francisco, succeeding Dr. Edward J. McCormick of Toledo, Ohio, who took office at a special inaugural session of the House of Delegates in the Hotel Commodore during the New York meeting.

Giving unanimous approval to a recommendation from its Reference Committee on Insurance and Medical Service, submitted as a substitute for eight different resolutions concerning the treatment of non-service-connected disabilities by the Veterans Administration, the House adopted the policy that such treatment should be discontinued except in cases involving tuberculosis or psychiatric or neurological disorders.

In taking this action, the House reaffirmed and adopted the following recommendation originally presented at the Denver Meeting last December by the Special Committee on Federal Medical Services:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the A.M.A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

"Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy.

"The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly.

"Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine were as follows:

"1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the under-

graduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body."

A minority report of the reference committee urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately won out, includes the following recommendations by the Board of Trustees:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinion.

"Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December, 1952, meeting. The Reference Committee on Medical Education and Hospitals recommended a substitute resolution which was adopted by the House after considerable discussion. The action abolishes the rule whereby approval may be withdrawn from an internship program which for two consecutive years fails to obtain at least two-thirds of its slated complement of interns. The resolution also calls for further study of the Essentials by a committee appointed by the Speaker of the House, at least half of whom are doctors in private practice not connected with medical schools or affiliated hospitals.

Among the many other actions taken, the House reaffirmed its endorsement of the principles embodied in Senate Joint Resolution No. 1 concerning international treaties or agreements which interfere with domestic laws or rights, and it approved a resolution deploring a derogatory article about the American Medical Association which appeared recently in the Home Life Magazine. The latter resolution was referred to the Board of Trustees for implementation.

THE ERA OF NOISE

"It has been said that where the appalling evil of medieval times was 'smells', that of our present day is noise." Willem Van de Wall.

It must have been unpleasant, at least to the fastidious, to live in medieval days when sewage ran freely in the gutters, when one had to go to a well for water, when tallow dips were the chief illuminant, and when indoor toilets were unknown. Whether unpleasant odors, stinks if you like those expressive Anglo-Saxon words, had any effect on the human nervous system is not, so far as we know, recorded. Probably nervous systems were tougher in those simpler days, but it is by no means impossible that some of the more sensitive citizens suffered from psychoneuroses of olfactory origin.

The story of the ill-effects of noise in industry goes back a century, for "boilermaker's deafness" has been known that long. Nowadays there are many occupations carried on in extremely noisy surroundings, and during the past twenty-five or thirty years increasing attention has been focussed on the effects of clamorous environments on health because such pathological conditions as deafness have not only industrial but, with compensation laws in so many states, also medico-legal aspects. The wars of the present century too have developed noises more intense than those occurring in medieval warfare, some of them sudden and violent such as bomb explosions, some also momentary but less intense, such as the explosion blasts of large guns, some

(*Foot Note. For extensive literature see Kryter, K.D., The Effects of Noise on Man. Jour. Speech and Hearing Disorders, 1950, Monograph Suppl. 1 and Fabricant, N.D., Am. Jour. Med. Sci., 1952, 223, 447).

more persistent as the roar of airplane engines. The vibrations — for noise is essentially a wave motion in an elastic medium, the atmosphere — may in explosions intense enough to produce "blast" actually rupture the ear drum, but usually noises loud and frequent enough produce loss of hearing by causing irreplaceable damage to the hair cells of the organ of Corti with at times secondary changes in the ganglion cells of the nerve fibers that terminate in the nerve cells. There are scientific methods for measuring the *sound pressure* level of noise in decibels and the *frequency* in cycles per second. But the purpose of this editorial is not so much to comment on the industrial aspects of noise as to discuss its effects on those exposed to the everyday sounds associated with modern life.

It should be noted first of all that, as would be expected, the sensitivity of individuals to noise, and also their range of hearing, vary tremendously. So-called norms of hearing range have been established but, after all, they are merely averages. For example, I happen to know a young engineer who can detect high-pitched noises inaudible to most human beings, though some animals would hear them without difficulty. Averages of the intensity and frequency of noises likely to cause damage, notably to hearing, have been published, but here again the enormous variability of individuals must be stressed. Some people are much more sensitive to noise than others, and at least partly as a result of these human factors, many papers on the effect of ordinary noise are lacking in scientific accuracy. Nevertheless it must be conceded that noise may be a factor in the health of the ordinary citizen.

"All manner of vague ills and ailments from insomnia and high blood pressure to inability to do mathematics or ride a bicycle, have been attributed to the baneful effects of noise of one kind or another."* As long ago as 1938 Lord Horder who obviously lives on a sometimes noisy London Street, cites the chief effects of noise as: (1) interference with sleep, (2) lowering of efficiency in both manual and mental work, (3) a contributory factor in the production of minor and at times major mental disease and (4) a cause of increased incidence of general ill-health when a quiet district becomes a noisy one. He points out that experimentally a loud noise may cause a temporary rise in blood pressure and also a temporary paralysis of stomach movements. Sudden noises may increase the metabolic rate, also the heart and respiratory rates. These are the same effects as are produced by *fear* and, considering that the British people have gone through two wars in recent years, are perhaps due not so much to the noise itself as the fear that it is due to exploding bombs or shells. Doctor Horder's description of his own reaction to hearing a car roar down his street at night, waking him from his "first sleep" are interesting because they represent the feelings of a thoughtful man, a physician, and a trained observer. He was disturbed by the knowledge that the motorist had cut out his silencer and had broken the law and that the police had done nothing about it, by the thought that the driver ignorantly thought that he was increasing his power by this maneuver, and by the suspicion that he was an exhibitionist. Doctor Horder and other observers have noted that loudness of noise is by no means the most important factor as some low degree noises are annoying. Suddenness and unexpectedness may be important, as is persistence, repetition, needlessness, and the fact that those affected by the clamor may have no control of it. All of these things, as he says, "get you down".

It is evident from this brief discussion that the effects of the ordinary noises of the modern world are both physical and psychic. If, for example, noise interferes with sleep it may result in undue fatigue, and as has been clearly shown by observation and by the effect of Communist third degree methods, loss of sleep lasting only 36 to 48 hours leads to serious mental and physical symptoms. McCartney claims that more young people break down from lack of relaxing sleep than from any other indiscretion. Grove states that psychiatrists regard noise as one of the most serious threats to our health. Continued exposure is said to destroy efficiency, produce fatigue, encourage inattention and lack of concentration, promote absenteeism, and make the victims jumpy, jittery and irritable. As a result neurasthenia and psychasthenia develop. Podolsky claims that actual insanity often occurs. Up to the present competent observers believe

(Foot Note. Davis, H. Arch. Industr. Hyg. and Occup. Med., 1951, 3, 227).

that both industrial and laboratory experiments reporting noise as adversely affecting work are open to criticism because of poor experimental methods and uncontrolled factors. The whole subject is a complex one worthy of continued and more accurate research. G. B.

RECOMMENDATIONS OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH FOR THE CONTROL OF POLIOMYELITIS

The following recommendations are presented as control measures in poliomyelitis:

A. GENERAL PRECAUTIONS DURING OUTBREAKS:

1. The Illinois Department of Public Health will inform physicians and the general public as to the prevalence or increase in incidence of the disease.

2. Early diagnosis is extremely important. Common early signs of polio are: headache, nausea, vomiting, muscle soreness or stiffness, stiff neck, fever, nasal voice and difficulty in swallowing with regurgitation of liquids through the nose. Some of these symptoms may be present in several other diseases but in the polio season they must be regarded with suspicion.

3. All children with any of these symptoms should be isolated in bed pending diagnosis. Early medical care is extremely important.

4. Avoid undue fatigue and exertion during the polio season.

5. Avoid unnecessary travel and visiting in areas where polio is known to be prevalent.

6. Pay special attention to practice of good personal hygiene and sanitation:

a) Wash hands before eating and at all times aviod unnecessary contact with the mouth and nose.

b) Keep flies and other insects from food.

c) Cover mouth and nose when sneezing or coughing.

B. SURGICAL PROCEDURES

1. Nose, throat or dental operations, unless required as an emergency, should not be done in the presence of an increased incidence of poliomyelitis in the community.

C. IMMUNIZATIONS AND INJECTIONS

1. The overall risk of clinical attack by poliomyelitis is so small and the evidence of increased severity of the disease following injections or inoculations so equivocal that this Department does *not* recommend withholding such injections during the poliomyelitis season.

2. Although some evidence exists that certain immunizations may increase the severity of paralysis in the extremity of injection in individuals who are incubating the disease at the time, the combination of chances for such to occur is extremely small and the problem is not at all a serious one. Therefore, the Department does *not* recommend postponement of immunizations except in epidemic areas.

D. GENERAL SANITATION, INCLUDING FLY CONTROL

1. Although there has been no positive evidence presented for spread of poliomyelitis by water, sewage, food, or insects, certain facts derived from research indicate that they *might* be involved in the spread.

a) *Water* — Drinking water supplies can become contaminated by sewage containing poliomyelitis virus. While no outbreaks have been conclusively traced to drinking water supplies, only water from an assuredly safe source should be used to prevent any possible hazards that might exist.

b) *Sewage* — Poliomyelitis virus can be found for considerable periods of time in bowel discharges of infected persons and carriers and in sewage containing such bowel discharges. Proper collection and disposal facilities for human wastes are essential to eliminate the potential hazard of transmission through this means.

c) *Food* — The infection of experimental animals by their eating of foods deliberately contaminated with poliomyelitis virus has been demonstrated in the laboratory, but no satisfactory evidence has ever been presented to incriminate food or milk in human outbreaks. Proper handling and preparation of food and pasteurization of milk supplies should reduce the potential hazard from this source. It is advisable that fruits and vegetables should be thoroughly washed, especially if they are to be eaten raw.

d) *Insects* — Of all the insects studied, only blow-flies and house flies have shown the presence of poliomyelitis virus. This indicates that these flies might transmit poliomyelitis. It does not show how frequently this might happen; it does

not exclude other means of transmission; nor does it indicate how important fly transmission might be in comparison with other means of transmission.

2. Fly eradication is an extremely important activity in maintaining proper sanitation in every community.

3. Attempts to eradicate flies by spraying of effective insecticides have not shown any special effect upon the incidence of polio in areas where it has been tried. Airplane spraying is not considered a practical and effective means in reducing the fly population of a city. The best way to control flies and any of the diseases they may spread is to eliminate fly breeding places. Eradicate flies by:

a) Control of manure piles by construction, spreading, and/or spraying to prevent fly breeding.

b) Proper storage, collection, and disposal of garbage and other organic wastes.

c) All privies should have both fly and rodent-proof pits.

Proper sanitation should be supplemented by using effective insecticides around garbage cans, manure piles, privies, etc. Use effective insecticide spray around houses or porches or paint on screens to kill adult flies.

E. HOSPITALS

1. There is no reason for exclusion of poliomyelitis cases from general hospitals if isolation is exercised, — rather, such admissions are necessary because of the need for adequate medical care by the patient.

2. Patients should be isolated individually, or with other cases of poliomyelitis in wards.

3. Suspect cases shall be segregated from known cases until the diagnosis is established.

4. The importations of cases to hospitals in a community where poliomyelitis is not prevalent has not been demonstrated to affect the incidence of the disease in the hospital community.

5. The attack rate among adults is initially small and the instances of cases among hospital personnel rare. Good isolation technique during the acute infectious period not only protects the other patients, but personnel handling the cases as well.

F. GAMMA GLOBULIN FOR HOUSEHOLD CONTACTS

1. The basic allocation of gamma globulin, which is in such extremely short supply, is being distributed for prophylaxis among *household* contacts of cases of poliomyelitis.

2. Physicians will request gamma globulin from full-time health departments for such contacts immediately upon diagnosis of the case in the household.

3. Gamma globulin will be furnished to physicians for all household contacts under 30 years of age and for any pregnant woman, irrespective of age or stage of pregnancy, who, in the opinion of her physician, has had intimate contact with a case.

4. Gamma globulin provides only temporary protection for 4-6 weeks and can only be expected to modify the severity of the attack occurring in the first week after injection.

G. GAMMA GLOBULIN IN EPIDEMIC AREAS

1. Gamma globulin will be made available for mass community prophylaxis in epidemic areas as defined by rigid criteria set up by the Office of Defense Mobilization.

2. The Department is scutinizing daily all reports of poliomyelitis from all areas of the State. Should any area reveal an incidence portending epidemic proportions, immediate investigation of the situation and consultation with local health authorities, local medical society gamma globulin committees and the State Gamma Globulin Distribution Committee will be undertaken to determine the need and practicality of mass prophylaxis.

3. Should the community situation be found to meet the criteria of incidence rate, the Department will immediately petition the Office of Defense Mobilization for gamma globulin from the national reserve for mass community prophylaxis.

4. Only children up to 15 years of age will be given gamma globulin in mass community prophylaxis programs.

5. The full-time health department (City, County or Regional Health Departments) will organize such programs with the assistance of community agencies and groups, to the end that the child population will be immunized rapidly before the peak of the outbreak has passed.

H. SWIMMING POOLS

1. Unsatisfactorily constructed or operated

swimming pools should be closed whether or not there is poliomyelitis in the community.

2. On the basis of available scientific information, the State Department of Public Health has no reason to expect that closure of properly equipped and operated swimming pools will have any effect on the ocurrence of occasional cases of poliomyelitis in communities.

3. In communities where a case of poliomyelitis has been associated with the use of a swimming pool, that pool and its recirculation equipment should be drained and thoroughly cleaned. (The State Department of Public Health should be contacted for specific cleansing procedures.) After these measures, the pool is ready for reopening.

4. Excessive exertion and fatigue should be avoided in the use of the pool.

5. Swimming in creeks, ponds, and other natural waters should be prohibited if there is any possibility of contamination by sewage or too many bathers.

I. SUMMER CAMPS

Summer camps present a special problem. The continued operation of such camps is contingent on adequate sanitation, the extent of crowding in quarters, the prevalence of the disease in the community and the availability of medical supervision. Full information is available from the Illinois Department of Public Health to camp operators and should be requested by the latter.

1. Children should not be admitted from areas where outbreaks of the disease are occurring.

2. Children who are direct contacts to cases of polio should not be admitted.

3. The retention of children in camps, where poliomyelitis exists, has not been shown to present increased hazards to these children. Futhermore, return of such children to their homes may introduce the infection to that community if it is not already infected. Similarly, there will be no introduction of new contacts to the camp and supervised curtailment of activity will be carried out, a situation unduplicated in the home. This retention is predicated upon adequate medical supervision.

4. If poliomyelitis occurs in a camp it is advisable that children and staff remain there, (with the exception of the patient, who may be removed, with the consent of the proper health authorities.) If they do remain in camp:

a) Provide daily medical inspection for all children for two weeks from occurrence of last case.

b) Curtail activity on a supervised basis to prevent overexertion.

c) Isolate all children with fever or any suspicious signs or symptoms.

d) Do not admit new children.

5. GAMMA GLOBULIN. The use of gamma globulin among intimate contacts to a case in camp may be instituted after investigation of the situation upon the full-time health officer of the jurisdiction. Intimacy of contact will be predicated upon the degree of intermingling with respect to sleeping quarters, dining facilities and activities among the units of the camp. Such investigations will be made immediately upon the occurrence of a *single* case.

J. SCHOOLS

1. Public and private schools should not be closed during an outbreak of poliomyelitis, nor their opening delayed except under extenuating circumstances and then only upon recommendation of the Illinois Department of Public Health.

2. Children in school are restricted in activity and subject to scrutiny for any signs of illness. Such children would immediately be excluded and parents urged to seek medical attention.

3. Closing of schools leads to unorganized, unrestricted and excessive neighborhood play. Symptoms of illness under such circumstances frequently remain unobserved until greater spread of the infection has occurred.

4. If poliomyelitis occurs or is suspected in a school:

a) The child should immediately be sent home with advice to the parents to seek medical aid, and the health authority notified.

b) Classroom contacts should be inspected daily for any signs or symptoms of illness and excluded if these are found.

K. RECREATIONAL FACILITIES

1. Properly operated facilities for recreation should not be closed during poliomyelitis outbreaks.

2. Supervised play is usually more conducive to restriction of physical activities in the face of an outbreak.

3. Playground supervisors should regulate activities so that overexertion and fatigue are avoided.

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR AUGUST

Sixteen clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will conduct 11 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The August clinics are:

August 5 — Hinsdale, Hinsdale Sanitarium

August 6 — Effingham, St. Anthony's School Gym

August 11 — East St. Louis, Christian Welfare Hospital

August 11 — Peoria, St. Francis Hospital

August 12 — Elgin, Sherman Hospital

August 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

August 13 — Springfield, St. John's Hospital

August 14 — Chicago Heights (Rheumatic Fever), St. James Hospital

August 19 — Chicago Heights, St. James Hospital

August 20 — Rockford, St. Anthony's Hospital

August 20 — Tuscola, Moose Hall

August 25 — Effingham (Rheumatic Fever), Douglas Township Building

August 25 — Peoria, St. Francis Hospital

August 26 — Springfield (Cerebral Palsy), Memorial Hospital

August 27 — Bloomington, St. Joseph's Hospital

August 28 — Chicago Heights (Rheumatic Fever), St. James Hospital

GRADUATE FORTNIGHT MEETING

The New York Academy of Medicine is holding its Twenty-Sixth Annual Graduate Fortnight this year from October 19-30, inclusive. The subject will be DISORDERS OF THE BLOOD AND THE BLOOD-FORMING ORGANS.

The program will consist of twenty evening lectures, six morning panel meetings and afternoon clinics presented by twenty participating hospitals in the metropolitan area, as well as a Scientific Exhibit.

A program and registration card will be sent to Non-Fellows of the Academy upon receipt of

a check, payable to The New York Academy of Medicine, for $10.00 for the entire program, or $5.00 for the *second week.*

We believe this Fortnight will be an outstanding event of practical interest to your readers, and hope that you will carry notice of it in your publication. When the complete program is in print, a copy will be sent you.

Robert L. Craig, M.D.
2 East 103 St.
New York 29, N. Y.

PAN-PACIFIC SURGICAL MEETING

Doctors are urged to make arrangements as soon as possible to attend the Sixth Pan-Pacific Surgical Congress to be held in Honolulu, Hawaii October 7-18, *1954.*

An outstanding program, including sessions in all divisions of surgery and related fields, promises to be of interest to all doctors.

The Association office has been appointed as travel agent for those attending the Congress and it is important that all hotel and travel reservations be made through the Honolulu headquarters of the Pan-Pacific Surgical Association.

For further information, please write to F. J. Pinkerton, M.D., Director General, PAN-PACIFIC SURGICAL ASSOCIATION, Suite 7, Young Hotel Building, Honolulu, Hawaii.

PSYCHIATRIC HOSPITALS

Psychiatric hospitals are in their present plight because people, by and large, want them that way and the differences in the efficacy of mental hospitals in different states, their attitude and atmosphere, therapeutic policies, diets, cleanliness, degree of overcrowding, and understaffing, and their reputations in their communities are direct indications of the level of social progress of the people who own these hospitals. Hospitals are like automobiles, preparatory schools, and most other things in the world; you get what you pay for. Although this generalization too is subject to some quibble, it is certain that therapeutic efficiency, as betokened by an interested and competent medical, dental, and nursing staff with their necessary tools and equipment to operate an aggressive treatment program, costs money. To be sure one can operate an expensive psychiatric hospital without these things. It depends on whether we choose to spend our money for furniture, carpets, draperies, pictures, and other window dressing; or for doctors, dentists, insulin, surgical equipment, X-ray, and other essential materials. If one can have both, so much the better; but it is difficult to have both without making the hospital a de luxe institution and depriving many people of their chance to get well because of economic barriers. Many mental hospitals have little of either the pleasant creature comforts or scientific programs. The mental hospital administrator knows this perhaps better than any one else. You pay your money and take your choice. As the sign in the old frontier saloon said, "Don't shoot the poor piano player -- he's doing the best he can." *J. Berkeley Gordon, M.D., Problems Of Psychiatric Hospitals. J. M. Soc. New Jersey, Mar., 1953.*

NEWS OF THE STATE



CHRISTIAN

Society News.—At a meeting of the Christian County Medical Society at the Taylorville Country Club, recently, Dr. A. A. Manson, Springfield, spoke on "Cardiovascular Problems, Pre and Postoperatively." At the business session, expression of appreciation was offered to the Macon County Medical Society for its offer to the Christian County Medical Society to appear as a regular feature of the former society's bulletin.

CLINTON

New Officers.—Dr. Fred Pulgram was chosen president of the Clinton County Medical Society recently; Dr. E. C. Asbury, vice president, and Dr. J. Q. Roane, secretary-treasurer. Dr. W. R. Ketterer was elected to the board of censors for three years; Dr. A. L. Fisher for two years and Dr. H. B. Warren for one year. Dr. Fred Pulgram was designated delegate to the 1953 annual meeting of the Illinois State Medical Society, and Dr. J. Q. Roane, alternate.

COOK

James Simonds Honored.—Dr. James P. Simonds, professor emeritus of pathology, Northwestern University Medical School, was guest of honor, May 17, at an open house in the Cancer Prevention Center, 17 West Huron Street. Dr. Simonds, who was president of the Chicago Medical Society when the clinic first was opened ten years ago, described the early organization and operation of the clinic.

Award Goes to Team in Brodie Operation.—The "unnamed 68" — doctors, nurses and technicians who took part in the treatment of the Brodie siamese twins, on May 22 received the annual Brown Derby Award of the Illinois Chapter of Sigma Delta Chi, a national professional journalistic fraternity, according to the Chicago Tribune. The presentation was accepted by Dr. Roger A. Harvey on behalf of 68 unnamed medical workers who aided in caring for the Brodie twins at the University of Illinois College of Medicine's Neuropsychiatric Institute.

Howard Shaughnessy Wins Pasteur Award.—Howard J. Shaughnessy, Ph.D., chief of laboratories in Chicago for the Illinois Department of Public Health, received the 1953 Pasteur Award of the Society of Illinois Bacteriologists at a meeting of the society, May 16, in Chicago. The Chicago Tribune reported that the award went to Dr. Shaughnessy for outstanding contributions in bacteriology. The presentation was highlighted with a talk by Dr. Shaughnessy on "Poliomyelitis—Past, Present and Future."

Art Snider Heads Science Writers.—Arthur J. Snider, Daily News science writer, was elected president of the National Association of Science Writers at a meeting in New York, June 2. Alton Blakeslee of the Associated Press was named vice president and John Pfeifer, magazine writer, secretary-treasurer.

Personal.—Dr. Vincent J. O'Conor, professor and chairman of the department of urology at Northwestern University Medical School, was elected president of the American Association of Genito-Urinary Surgeons at its meeting in Hot Springs, Va. Dr. Norris J. Heckel was named a member of the association's council after serving as secretary for eight years.—Dr. Leroy H. Sloan, clinical professor of medicine, University of Illinois College of

Medicine, was installed as president of the American College of Physicians recently.

Special Society Elections.—Dr. Douglas N. Buchanan was named president of the Chicago Neurological Society at a meeting May 12; Dr. Meyer Brown, vice president, and Dr. Leo A. Kaplan, secretary-treasurer.—Officers of the Chicago Pediatric Society, chosen at its May 19 meeting, are: Alfred S. Traisman, president; Eugene T. McEnery, vice president; Matthew M. Steiner, secretary; Maxwell P. Borovsky, treasurer; Alvah L. Newcomb, Craig D. Butler, and George F. Munns, executive committee, and Ralph H. Kunstadter, editor.—At a meeting of the Chicago Society of Anesthesiologists, Dr. Geraldine Light was named president; Dr. David M. Porte, vice president, and Dr. Julius H. Bolgla, secretary-treasurer.—At the May 27 meeting of the Illinois Pyschiatric Society, the following officers were elected: Alfred P. Bay, Manteno, president; H. H. Garner, vice president; Louis B. Shapiro, secretary-treasurer; Jules H. Masserman and Helen McLean, councilors. With the exception of Dr. Bay, all are of Chicago.

University News—Dr. Ralph W. Gerard was the guest speaker at the 25th annual meeting of the Chicago Colleges of the University of Illinois Chapter of the Society of Sigma Xi Thursday, May 21, at the Chicago Illini Union. Dr. Gerard, professor of neurophysiology at the University of Illinois College of Medicine, spoke on "Nerve Function and Metabolism of the Nervous System."

Appointments at Chicago Medical School.—The following appointments to the faculty of the Chicago Medical School are announced by President John J. Sheinin: Dr. Irving J. Shapiro, associate professor of urology; Dr. Herman M. Solomay, associate professor of clinical genito-urinary surgery; Dr. Louis Edidin, assistant professor of clinical medicine; Dr. William F. Lichtman, assistant in orthopedic surgery; Dr. Marvin Padorr, assistant in pediatrics; Dr. Samuel Nien-Tsu Wong, instructor in surgery; Rogert W. Poborsky, associate in orthopedic surgery; Herbert Korol, instructor in medicine, and Myron Feld, associate in psychiatry.

Grants for Research.—Over $78,000 in new and renewed grants for research have been awarded to the Chicago Medical School recently, according to an announcement by President John J. Sheinin. Dr. Ben B. Blivaiss, department of physiology and pharmacology, with his two collaborators, Drs. Russell O. Hanson and Phillippe Shubik, receives a new grant of $6,192 for one year from the National Cancer Institute, U.S. Public Health Service, for studies on "Mechanism of Experimental Induction of Testicular Tumors in Mice." Dr. Hans Elias, department of anatomy, receives two grants: (1) renewal of $4,000 from U.S. Public Health Service for studies on "The Architecture of the Adrenal Cortex in Normal and Hypertensive Human Subjects"; (2) new grant of $11,600 for a period of two years from the National Cancer Institute for studies on "Morphology of Carcinoma of the Liver." Dr. Harold Koenig, department of anatomy, receives a renewal of $22,000 from U.S. Public Health Service for "Morphologic and Quantitative Study of the Nucleoprotein in Living Cells Grown in Vitro and the Effect of Noxious Agents." Dr. Aldo A. Luisada, department of medicine, receives two grants from the Chicago Heart Association: (1) a new award of $9,700 for "Studies of Heart Sounds and Murmurs in Normal Children"; and (2) $500 to complete payment on apparatus. Dr. Philippe Shubik, department of surgery, receives a cancer teaching grant renewal in the amount of $25,000 from the National Cancer Institute.

Memorial to Dr. Bachmeyer.—A memorial service for the late Dr. Arthur C. Bachmeyer, dean of the United States medical educators and director emeritus of the University of Chicago Clinics, was held at 4 p.m. Friday (May 29) at Bond Chapel at the University.

Dr. Bachmeyer, who died (May 22) at Washington National Airport of a heart attack, was interred at Cincinnati, Ohio, May 27.

Speakers at the University memorial service were Vice-president R. Wendell Harrison, Dr. Lowell T. Coggeshall, dean of the division of biological sciences, and the Rev. Granger E. Westberg, chaplain of the University Clinics.

Dr. Bachmeyer, who had the longest term of deanship of any of the nation's medical educators, was formerly president of the American Association of Medical Colleges (1951), the American College of Hospital Administrators (1940) and of the American Hospital Association (1926).

At the University of Chicago, where he served as associate dean of the University's medical and biological division from 1935 until his retirement in 1951, Dr. Bachmeyer also served as director of the University's graduate program in hospital administration and as a member of the student-selection committee of the Medical School.

He was also consultant to the University's ten-million-dollar medical building program, including the Argonne Cancer Research Hospital, recently completed on the Midway campus by the Atomic Energy Commission.

The 1950 recipient of the American Hospital Association award of merit, Dr. Bachmeyer served as director of the Commission on Hospital Care. From 1944 to 1946, the commission investigated hospital needs of the nation, out of which grew the Hill-Burton act to provide federal funds for construction of hospitals in critical areas.

Following his University retirement, Dr. Bachmeyer served as director of the Commission on the Financing of Hospital Care.

Dr. Bachmeyer, in addition to his University and national appointments, was a director of the Chicago Blue Cross plan, chairman of the editorial board of **Modern Hospital,** and treasurer of the American Hospital Association since 1946 and of the American Medical Congress. He was a charter member of the American College of Hospital Administrators.

KNOX

Society News.—Dr. A. M. Duff, Galesburg, showed a movie on atomic warfare and its relation to medicine at a recent meeting of the Knox County Medical Society in Galesburg.

LAKE

Society News.—Dr. Kenneth C. Johnston, assistant professor of bronchoesophagology, University of Illinois College of Medicine, discussed "Bronchoscopy as Related to Bronchogenic Carcinoma" before the Lake County Medical Society at a recent meeting at the Lake County Tuberculosis Sanatorium, Waukegan.

Personal.—Dr. James W. Kopriva, Antioch, was elected to membership in the Lake County Medical Society by transfer from the Chicago Medical Society, according to the Bulletin of the society.

LOGAN

Personal.—Dr. William W. Fox, superintendent of the Lincoln State School and Colony, discussed the "State Program for Handicapped Children" before the Council of Social Agencies recently.

MACON

Society News.—Dr. Ben W. Lichtenstein, clinical professor of neurology, University of Illinois College of Medicine, discussed "Differential Diagnosis of Headache" before the Macon County Medical Society in Decatur, May 26.

SANGAMON

Society News.—Dr. Joseph A. Hardy, professor and chairman, department of obstetrics and gynecology, St. Louis University School of Medicine, St. Louis, discussed "Gynecological Headaches" before the Sangamon County Medical Society recently.

VERMILION

Society News.—Dr. William H. Browne, clinical professor of obstetrics and gynecology, University of Illinois College of Medicine, addressed the Vermilion County Medical Society at its June 11 meeting at the Hubbard Trail Club, Rossville. His subject was "Diagnosis and Treatment of Functional Uterine Bleeding." This was an all day meeting of the society highlighted by an afternoon of golf.

WINNEBAGO

Society News.—Marjorie Shearon, Ph.D., Washington, D. C., addressed the Northern Illinois Chapter of the Illinois Academy of General Practice recently at the Faust Hotel, Rockford, on "Galloping Socialism."

GENERAL

First Surgical Research Scholarship Available.—The board of regents of the American College of Surgeons has established the first of several contemplated scholarships in the field of research for promising young men seeking a career in academic surgery, and who have recently finished or who are in the final months of their residency training program. Although the college is able to support only one scholarship at the present time, it is believed that through the efforts of fellows and various organizations interested in this project support of additional research scholarships will be assumed.

Candidates must obtain the approval of the chairman of the department of surgery, dean of the same medical school, and the authority of an executive officer of the university making the proposal. Preference will be given to an American or Canadian citizen.

Successful candidates will receive $20,000 over a three year period, to be divided as follows: $6,000 for the first year, $6,500 for the second year, and $7,500 for the third year. The medical school or institution sponsoring a successful candidate may supplement this amount with the permission of the Committee on Selection of the American College of Surgeons.

Inquiries may be addressed to the Research Scholarship Committee, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

Conference on Exceptional Children.—Ways to insure the handicapped child against segregation and isolation in his daily activities will be the topic of discussion at the Tenth Governor's Conference on Exceptional Children scheduled for Friday, September 25, at the Palmer House in Chicago. Plans for this one-day conference, which is sponsored by the Illinois Commission for Handicapped Children, include sectional meetings and workshops to consider how the handicapped child can be more fully included in the main-stream of childhood experience.

People from many sections of the state are participating in planning the conference program. Among the group meetings being arranged are: The Handicapped Child in the Regular School Program; The Handicapped Child in the Community Recreation Program; The Pre-School Handicapped Child; The Role of the Social Worker in Helping the Handicapped Child Toward Normal Living; The Institutionalized Child and The Community.

The conference is open to all persons concerned with handicapped children, parents, professional workers, and interested citizens. There are no registration fees.

Inquiries concerning the conference may be directed to the Commission, at 160 North LaSalle Street, Chicago 1, Illinois.

The Commission for Handicapped Children is a state agency with responsibility to study the needs of both the physically and the mentally handicapped children in Illinois, and to promote a program of adequate services for them.

"How's Your Health" Takes Summer Vacation.— With the June 11 telecast, **"How's Your Health"** left the air for a summer vacation. **"How's Your Health"** is produced by the **Educational Committee** of the **Illinois State Medical Society** in cooperation with **WGN-TV.** Since the last issue of the Illinois Medical Journal, the following telecasts have been presented:

Joseph K. Freilich, assistant professor of clinical medicine, Chicago Medical School, May 18, "The Case of the Elusive Cancer." **Clay-Adams Company** participated in this telecast by providing equipment.

Oscar Sugar, assistant professor of neurological surgery, University of Illinois College of Medicine, May 25, Pathways of Pain."

Louis R. Limarzi and **Paul L. Bedinger,** associate and clinical professors of medicine, respectively, University of Illinois College of Medicine, June 1, "The Story of Blood."

Carl J. Marienfeld, assistant professor of pediatrics, University of Illinois College of Medicine, June 11, "Your Child's Heart Murmur". **Cambridge Instrument Company** and **Clay-Adams Company** both participated in this telecast by providing equipment.

Your Doctor Speaks over **FM Station WFJL.**— In the radio series "Your Doctor Speaks" over **FM Station WFJL,** the following physicians appeared in transcribed broadcasts under the auspices of the Educational Committee of the Illinois State Medical Society:

Ernest D. Bloomenthal, member of the surgical staff, Michael Reese Hospital, May 21, on Disease of the Gallbladder.

Donald H. Atlas, Mount Sinai Hospital, May 28, Pitfalls of Self-Medication.

Elmer E. Swanson, member of staff, South Chicago Community Hospital, June 4, Spring Fever in Disguise.

Irwin Dritz, director, department of anesthesia, Cook County Hospital, June 11, on Modern Anesthesia.

Lectures Arranged Through the Educational Committee of the **Illinois State Medical Society:**

John L. Reichert, West Area Business and Professional Women's Clubs, June 15, on Recent Developments in Poliomyelitis.

Alfred Flarsheim, Mother's Club of St. Paul's Church, September 15, on Psychosomatic Medicine.

Lectures Arranged Through the **Scientific Service Committee** of the **Illinois State Medical Society:**

Herbert L. Schmitz, Chicago, Kane County Medical Society in Aurora, June 10, Surgical Lesions of the Breast.

Armand J. Mauzey, Chicago, Henry County Medical Society in Geneseo, September 9, on Diagnosis and Treatment of Endometriosis.

Paul K. Anthony, Chicago, La Salle County Medical Society in La Salle, September 10, on Influenzal Meningo-Encephalitis and Its Management.

Warren H. Cole, Chicago, DeKalb County Medical Society in Sycamore, September 22, on Geriatric Surgery.

DEATHS

Arthur C. Bachmeyer, retired, Chicago, who graduated at the University of Cincinnati College of Medicine in 1911, died suddenly of a heart attack at the Washington National airport, May 22, aged 66. He was director emeritus of the University of Chicago Clinics and associate dean of the university's division of medical and biological sciences.

Marcellin Jean Chiasson, Lyons, who graduated at Loyola University School of Medicine in 1916, died April 4, aged 70, of pulmonary embolism. He was affiliated with MacNeal Memorial Hospital in Berwyn.

Isaac J. K. Golden, Chicago, who had practiced medicine on Chicago's northwest side over fifty years, died May 19, aged 81.

Newland Augustus Goodwin, Chicago, who graduated at the Detroit College of Medicine in 1892, died March 21, aged 83, of arteriosclerotic heart disease, following a fracture of the femur as the result of a fall.

Harry G. Hardt, retired, Chicago, who graduated at Rush Medical College in 1900, died June 5, aged 76. He was a member of the original staff of the Evangelical Hospital and had practiced medicine in Chicago more than fifty years.

Robert Meredith Hathaway, Hamilton, who graduated at Drake University College of Medicine, Des Moines, in 1909, died April 1, aged 70, of acute myocardial infarction.

Ira Milton Henderson, Chicago, who graduated at Northwestern University Medical School in 1922, died February 26, aged 62.

Lawrence J. Hughes, Elgin, who graduated at Rush Medical College in 1902, died May 20, aged 73. He had practiced medicine in Elgin for 43 years.

Lt. Richard B. Hull, Springfield, who graduated at Northwestern University Medical School in 1946, died May 18, aged 32, in Korea, while in the service of his country.

Karl Heinrich Kahn, Chicago, who graduated at Julius-Maximilians-Universität Medizinische Fakultät, Würzburg, Bavaria, Germany, in 1903, died March 25, aged 73.

Joseph J. Lebowitz, Chicago, who graduated at Northwestern University Medical School in 1914, died May 13, aged 62. He was president of the board of directors of South Chicago Community Hospital.

David Lieberthal, Chicago, who graduated at Medizinische Fakultät der Universität, Wien, Austria, in 1894, died June 10, aged 86. He was professor and head of the department of dermatology at Loyola University School of Medicine from 1910 to 1914, and was a member of the original staff of the Columbus Memorial Hospital.

Franklin Maurer, Springfield, who graduated at Northwestern University Medical School in 1908, died May 24, aged 69. He practiced medicine in Springfield since 1910.

Allen Jay Miller, Chicago, who graduated at the Medical College of Ohio, Cincinnati, in 1894, died February 23, aged 83, of arteriosclerotic heart disease and diabetes mellitus.

George Elmer Miller, Chicago, who graduated at Rush Medical College in 1928, died March 2, aged 64, of periarteritis nodosa. He was formerly on the faculty of his alma mater.

Richard Jasper Miller, Kincaid, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died February 8, aged 67.

Herman Albertus Moje, Chicago, who graduated at the National Medical University, Chicago, in 1907, died April 11, aged 66, of carcinoma of the intestine and chronic myocarditis.

Elliot Rector Motley, Kinderhook, who graduated at the College of Physicians and Surgeons, Keokuk, in 1897, died March 11, aged 79, of cerebral thrombosis.

Simon F. Salinger, retired, Chicago, who graduated at the University of Pittsburgh School of Medicine in 1897, died June 4, aged 92.

Jacob Clay Stone, retired, Oneida, who graduated at Kentucky University Medical Department in 1903, died January 13, aged 75, of cerebral hemorrhage and arteriosclerosis.

Dr. John F. Tenczar, River Forest, who graduated at the University of Illinois College of Medicine in 1927, died recently, aged 53. He was a staff member of St. Mary of Nazareth Hospital for 24 years.

Francis E. Thornton, retired, Chicago, who graduated at Bennett Medical College in 1888, died May 14, aged 88. Until his retirement, he was a member of the staff of the Norwegian-American Hospital.

William Hanseord Wilson, Danville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died March 11, aged 68. He was a member of the staff of St. Elizabeth Hospital, Danville.

Ernest J. Worthington, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died May 23, aged 62.

SPLEEN INJURIES

In injuries of the spleen, it has been shown by Foster and Webb that the left part of the diaphragm may be elevated and the stomach pushed to the right as shown by its gas outline. Inspection may reveal swelling or absence of respiratory motion in the left upper quadrant. On palpation, tenderness and a sense of fullness frequently can be detected, and on percussion, gastric tympany will be obliterated and a dull note heard in the lower part of the chest posteriorly and in the axilla. Often there may be fracture of ribs. As an aid in diagnosis in splenic injuries, Max Saegesser of Berne advises use of the left splenic point, pressure being applied between the sterno-mastoid and the scalenus anticus. In all these injuries seen by him, pressure here started up violent pain, contrasting with the same pressure on the right side. The reason is that sensory branches from the capsule run to the trunk of the left phrenic nerve. This sign is present even when rupture is incomplete, and when there is a subcapsular hematoma with capsule intact, Saegesser believes that this sign alone justifies exploration of the spleen. The diagnosis of rupture of the spleen, besides the tender point mentioned above, may be made by abdominal aspiratory puncture with a fine needle to determine if there is free blood. Another important diagnostic aid is to give the patient a small swallow of barium and take an X-ray in the Trendelenberg position. If there is free fluid in the lesser sac or in the upper quadrant, there will be an area of separation between the barium in the cardia and the diaphragm. In one case of our own at the City Hospital, this was the final diagnostic aid which caused us to explore a child with a ruptured spleen and secondary hemorrhage. *Frederic W. Bancroft, M. D., Elective Versus Emergency Abdominal Surgery. Pennsylvania M.J., Jan. 1953.*

PUBLIC HEALTH AIMS

In tuberculosis, cancer, heart disease, diabetes, arthritis, and other chronic diseases we might well aim for levels of control that involve every practicing physician giving ambulatory treatment, either preventive or curative, in his office. Thus as a key element in its chronic disease effort, the Public Health Service continues to support an unremitting search for case-finding techniques that may be applied on a wide scale and for therapies that may ultimately be placed in the hands of the general practitioner as well as the specialist. Certainly, facing up to the problems of chronic disease and an aging population, public health agencies need to encourage and develop many new types of partnership. There is strong support for chronic disease control and for health services to the aging. Yet state and local health services in most of these fields are scanty and scattered. While new techniques for chronic disease control and hygiene of the aging remain in a twilight zone between experiment and widespread use, it may be that a "bridge" type of community institution with research, educational, and limited service functions is needed to speed the sound application of scientific advances. *Leonard A. Scheele, M.D., The State Of The Nation's Public Health Services. Pub. Health Rep., Feb. 1953.*

DOCTOR OF THE FUTURE

In the eyes of others, our status as American physicians is not yet all that might be desired. I remember that in 1926 I was the guest of Dr. Lunsgaard, professor of experimental medicine in the University of Copenhagen, who then had been newly appointed to the chair after several years of postgraduate study in the United States, most of it in Philadelphia. I asked him what he thought of medicine in the United States and whether he had at any time considered the possibility of staying in this country. He replied: "Your medical science is moving ahead rapidly. It has a great future. But," he continued, "your country does not treat your doctors well enough. It is the bankers and industrial magnates and movie heroes whom you honor, with both money and prestige. Here in Denmark no one is rich; but our doctors, especially our professor-doctors, are as well off and as well thought of as any one." *Thomas Parran, M.D., The Doctor Of The Future. Pennsylvania M.J., Jan. 1953.*

THE EKG

When the electrocardiogram is within the limits of normal, it is sometimes necessary to try to induce an attack and to record the electrocardiographic changes if they occur. This is done by having the patient perform an amount of exertion which ordinarily precipitates pain. In the physician's office the patient has a certain sense of security, hence the emotional factor is often absent. As a result he may be able to perform many times the amount of exercise without experiencing the symptom of pain. Because of the risk of causing myocardial infarction or sudden death, exercise tests should be limited to the following:

1. All persons under 40 years of age because of the obvious implications of the diagnosis.

2. In patients 40 through 49 years of age the subject may elect to have the procedure performed after an explanation has been given.

3. Age is not a factor when the resting electrocardiogram is normal and the individual is in a "key position," i.e., when there is a question of military service or benefits, application for insurance, or a question of insurance benefits, or litigation of various sorts is involved. The test may be extremely important in the case of patients with atypical symptoms. *Joseph M. Barker, M.D. The Electrocardiographic Manifestations of Coronary Artery Heart Disease. Med. Ann. District of Columbia, Sept.* 1952.

BCG is harmless if prepared and used properly; it produces a certain degree of immunity, and it should be used to immunize the more vulnerable groups in the population. These groups are doctors, medical students and nurses; hospital and laboratory personnel; individuals unavoidably exposed to infection in the home; patients and employees in custodial institutions, and children and certain adults considered to have inferior resistance and living in communities where tuberculosis is unusually prevalent. James E. Perkins, M.D., Bulletin of the National Tuberculosis Association, April, 1953.

In all the attention now being paid to chemotherapy, it should not be forgotten that bed rest is just as necessary as ever in the treatment of tuberculosis, All forms of collapse therapy are still useful in suitable cases. Whereas chemotherapy has not shortened the duration of hospital stay, it has helped the recovery of many patients who would otherwise have succumbed. The lives of many additional patients have been prolonged indefinitely, although the disease was not arrested. William S. Schwartz, M.D., The New England J. of Med., April 23, 1953.

HOUSE OF DELEGATES



The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 19, 1953.

The meeting was called to order at 3:15 P.M. by the President, Dr. Leo P. A. Sweeney, Chicago.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Harlan English, Chairman.

DR. HARLAN ENGLISH, Danville: The Credentials Committee has certified 133 delegates and 21 officers and members of the Council, making a total of 154.

DR. MATHER PFEIFFENBERGER, Alton: I move you, Mr. President, that this number of 154 constitute the voting strength of this House of Delegates for this session. (Motion seconded by Dr. W. W. Fullerton, Sparta, and carried).

THE PRESIDENT: The Chair next wishes to pay tribute to Dr. Robert H. Hayes, Chicago, who has been a member of the House of Delegates since 1912.

The next order of business is the roll call by the Secretary.

DR. MATHER PFEIFFENBERGER, Alton: I move you, Mr. President, that the attendance slips constitute the official roll call, for this session. (Motion seconded by Dr. J. S. Lundholm, Rockford, and carried).

THE PRESIDENT: The next item on the agenda is the approval of the minutes of the 1952 meetings as published in the July and August 1952 issues of the Illinois Medical Journal.

DR. G. HENRY MUNDT, Chicago: I move that the minutes be approved as published. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried).

THE PRESIDENT: It is now my privilege to present the Outstanding General Practitioner Award to James S. Templeton of Pinckneyville.

James Scott Templeton, M.D. was born at Pinckneyville in 1871, the son of Rev. William Harris and Margaret Eliza (Craig) Templeton. He was a student at Southern Illinois Teachers College at Carbondale, 1889-91, and received his medical degree in 1898 from the St. Louis College of Physicians and Surgeons. Soon after graduation he located in his home town of Pinckneyville, and has maintained his practice there continuously to this date.

He has always been interested in civic activities, and has been a promoter of his home town throughout his entire life. He served as mayor of Pinckneyville, president of the local school board, and has always been active in church work. He has been a trustee of the First Presbyterian Church for 40 years, and chairman of the Board for 25 years. He aided materially in getting the city water works, telephone system and a modern sewage disposal system for his home town. He has likewise been very prominent in the activities of the local Chamber of Commerce. He was president of the Illinois State Medical Society in 1941. On October 19, 1952, Dr. Templeton was named Outstanding General Practitioner of Illinois for 1953. I have here a plaque which I now present to Dr. Templeton. Dr. Templeton, congratulations.

DR. TEMPLETON: Words cannot express my feeling at this time. After more than 50 years of service to humanity this comes as a climax, not that I expect to pass on, because I can look over the audience and see others who have passed the number of years I have. I want to thank the Illinois State Medical Society for this honor. Gentlemen, I have

tried to do the right thing by my country and my fellow citizens. I have no excuses to make. I have not gotten rich in finances but I have worked on year to year and I am still working. It is a great pleasure to me to attend the meetings of the greatest state medical society in the world. I have attended at least 30 years without missing and I hope to attend at least a few more. Again, I want to thank you and hope that the Illinois State Medical Society will keep pace as it has in the last 50 years with the work of the world. I am proud of what medicine has done in the last 50 years. We canot expect to ever do again as much in progress as we have but if we continue our work, take good care of the sick and the poor, there will still be advances in the health of our world. Again I thank you.

THE PRESIDENT: I would like to introduce the Executive Secretary of the Indiana State Medical Society, Mr. James Waggoner. He is making speeches all over and I think he should say something here.

MR. WAGGONER: It is certainly a pleasure to visit the Illinois State Medical Society at its annual meeting, and I am glad to find out how you do things in Illinois because we hear about it frequently from the Chicago population. It is a pleasure to listen and not have duties to perform.

THE PRESIDENT: Mr. Waggoner was very nice to us when we attended the meeting of the Indiana State Medical Association.

THE SECRETARY: We have one gentleman here who would like to give you an expression of greeting, Mr. Earl Benedict, Convention Manager of the Hotel Sherman.

MR. BENEDICT: We are certainly glad to see you back and I wish I could go down the room and shake each of your hands. We do like to have you here. It makes me think of doctors and in the midst of May we do think of you doctors. During the last year we made some few changes; the lobby will be finished before it gets cold. On behalf of the Hotel Sherman it is my pleasure to present this gavel to the President, but we are sure you are going to take it home just as it is because these boys are going to behave themselves.

THE PRESIDENT: We are very grateful to you Mr. Benedict for the fine service you have given us.

I should like to introduce the President of the Wisconsin Medical Society, Dr. Joseph Griffith of Milwaukee.

DR. GRIFFITH: It is a great pleasure to be here and attend the meeting of the House of Delegates of the Illinois State Medical Society. The people of Wisconsin and the people of Illinois are a great deal alike in many ways, the same background that goes back to Marquette and Joliet and LaSalle and some of the other men who discovered this country. I do not believe there is anybody here but who believes we live in the greatest country in the world. No matter how those east of the Alleghenies and west of the Rockies feel, this part of the Middle West is the best part of our country. Chicago alone has three members in the major leagues. We in Wisconsin like to feel that we have some roots in Chicago. When you go back over the history of medicine you find Billings, Favill, Sippy, John B. Murphy, Senn, and A. J. Ochsner all were born in Wisconsin.

I suppose in the medical lines we have some of the same problems. We have problems in our own state and we have problems on the national scene. I think we have come into an era of better relationship with government. It was my pleasure to visit in Washington in the last month and to see the new office of the A.M.A. I had the pleasure of meeting a very smart woman, Mrs. Oveta Culp Hobby. There is great concern about how the new department will work on the national scene, but she has made some statements that sound very good. She has 37,000 employees and the train is going 90 miles an hour; she will have trouble slowing down to 80. In her first press conference she went back to the preamble of the constitution, ". . . to provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, etc . . .", and not as the Department has in the past, "to provide public welfare". She sincerely believes that her department will function with tax reduction, less budget, and less emphasis on some of the essential things in public welfare. I think great concern is manifested in some parts of the country but we probably do not have to fear too much. So as representative of the doctors in Wisconsin, may I say it is a pleasure to be here and I hope you will come up to Wisconsin some time and bring your golf sticks and muskie rods.

THE SECRETARY: We had invited the President of the Kentucky State Medical Association, Dr. R. Haynes Barr of Owensboro. I have just received a letter from Mrs. Barr stating that Dr. Barr had a fatal coronary on May 5.

DR. ROBERT H. HAYES, Chicago: I move that a telegram of condolence be sent to Mrs. Barr. (Motion seconded by Dr. Carl Uthoff, Carthage, and carried).

THE PRESIDENT: In the exhibit hall there is a booth for the World Medical Association. I would suggest that you join it. Dr. Louis Bauer, President of the A.M.A., and Secretary of the World Medical Association, will be here tomorrow. This organization seeks to form a better liaison between the doctors of the world, to raise the standards of medical education and medical care throughout the world, and to improve national relations. You should step down to the booth.

The next order of business is the appointment of the Reference Committees.

1. *Committee on Credentials*: Harlan English, Danville, Chairman, Eugene T. McEnery, Chicago, M. M. Hoeltgen, Chicago, and W. E. Kittler. This committee will meet in Room 102 on the first floor at

10:00 o'clock on Tuesday morning, May 19, and also at 2:00 o'clock Tuesday afternoon in the Louis XVI Room to certify delegates.

2. *Committee on Attendance*: John E. Bohan, Alexis, Chairman, Charles E. Ahlm, West Frankfort, Walter C. Bornemeier, Chicago, Carl F. Steinhoff, Chicago. This committee will distribute and collect attendance slips, voting slips, and act as Sergeants at Arms when necessary.

3. *Committee on Reports of Officers* — to receive and report on the reports of the President, President-elect and Secretary-Treasurer. The Committee will meet in Room 133 at 10 A.M., Wednesday, May 20. G. Henry Mundt, Chicago, Chairman, Harry J. Dooley, Oak Park, Harry Mantz, Alton, and Tom Kirkwood, Lawrenceville.

4. *Committee on Reports of Councilors* — to receive and report on reports of the Chairman of the Council, from the 11 Councilor Districts, and of the Councilor at large. To meet in Room 110 at 10 A.M., Wednesday, May 20. Pliny R. Blodgett, Chicago Heights, Chairman, J. K. Rosson, Tamms, M. D. Murfin, Decatur, and John Wall, Chicago.

5. *Committee on Reports of Standing Committees* — to receive and report on reports of Committee on Medical Service and Public Relations, Medico-Legal Committee, Committee on Archives, Committee on Medical Education and Hospitals, Committee on Medical Benevolence, Committee on Medical Testimony, and Grievance Committee. To meet in Room 106 at 10 A.M., Wednesday, May 20. Bernard Klein, Joliet, Chairman, Paul Blackburn, Chicago, Norman L. Sheehe, Rockford, John R. Wolff, Chicago.

6. *Reference Committee "A"* — to receive and report on reports of The Educational Committee, Committee on Postgraduate Education, Scientific Service Committee, Fifty Year Club Committee, Medical Economics Committee, and Committee on Physical Medicine and Rehabilitation. To meet in Room 105 at 10 A.M., Wednesday, May 20. James H. Hutton, Chicago, Chairman, Robert M. Watrous, North Chicago, Charles Eck, Chicago, J. Eric Gustafson, Stockton.

7. *Reference Committee "B"* — to receive and report on reports of Advisory Committee to Illinois Public Aid Commission, Advisory Committee to United Mine Workers, Constitution and By-Laws Committee, Committee on Voluntary Prepayment Plans, Committee on Mental Health, Committee on Diabetes, Committee on Necrology. To meet in Room 104 at 10 A.M., Wednesday, May 20. Max Hirschfelder, Centralia, Chairman, W. A. Monaghan, Taylorville, Anders J. Weigen, Chicago, S. M. Goldberger, Chicago.

8. *Reference Committee "C"* — to receive and report on Committee on Cancer Control, Committee on Tuberculosis Control, Advisory Committee to Veterans' Administration, Committee on Military Affairs and Emergency Medical Service, and Committee on Blood Banks. To meet in Room 113 at 2 P.M., Wednesday, May 20. Warren W. Furey, Chicago, Chairman, Harold W. Miller, Chicago, Elliot Burt, Peoria, and James C. Ellis, DeKalb.

9. *Reference Committee "D"* — to receive and report on reports of Committee on Rural Medical Service, Crippled Children's Clinic Committee, Committee on Industrial Health, Maternal Welfare Committee, Ethical Relations Committee, Committee on Nursing, and Committee to Investigate Coroner's Office. To meet in Room 110 at 2 P.M., Wednesday, May 20. J. C. Redington, Galesburg, Chairman, Fred H. Muller, Chicago, Oscar Hawkinson, Oak Park, and W. H. Schowengerdt, Champaign.

10. *Reference Committee "E"* — to receive and report on the reports of The Editors, Illinois Medical Journal, the Journal Committee and the Editorial Board, Committee on Scientific Work, The President of the Woman's Auxiliary, Advisory Committee to the Woman's Auxiliary, and Committee on Cardiovascular Disease. To meet in Room 106 at 2 P.M., Wednesday, May 20. Charles H. Phifer, Chicago, Chairman, H. D. Junkin, Paris, Kenneth Schnepp, Springfield, and George Turner, Chicago.

11. *Reference Committee on Miscellaneous Business* — to receive and report on the reports of the following Committees, and on any other business referred by the President: Committee on Nutrition, Committee on Medical History, Committee on Inter-professional Relations, Delegates to the A.M.A., Advisory Committee on Military Affairs. To meet in Room 104 at 2 P.M., Wednesday, May 20. Percy E. Hopkins, Chicago, Chairman, G. F. Cummins, Metropolis, E. A. Piszczek, Chicago, and J. A. Mathis, Pinckneyville.

THE PRESIDENT: The next order of business is the consideration of annual reports as published in the Handbook, and the presentation of supplementary reports if desired.

REPORT OF THE PRESIDENT
LEO P. A. SWEENEY, CHICAGO

This is to be my final report to you as the President of the Illinois State Medical Society. The year has brought many changes and challenges, nationally and at the state and local levels. Nationally, there was a mandate from the people to turn from socialization and nationalization of our industries and services, when the voters put a Republican in the White House for the first time in twenty years. This change overshadowed all others and was reflected in our own state by a change to a Republican Governor. Certainly, the physicians of this and other states played no small part in the awakening of the national conscience. From this it should be apparent that the influence of the medical men and women is one of major importance in reckoning with fundamental problems.

Public opinion is a guide to our representatives in government. If we expect our opinions to be considered, we must transmit our thoughts and conclusions to those who make the decisions. Close liaison be-

tween us as individuals and our legislators in Springfield and Washington should help promote good government.

Physicians must increase their activities in community affairs because to be effective they must join and serve the organizations and agencies interested in political, social and economic life. Civic minded doctors might serve on School Boards, Boards of Health, in Church and service organizations for the furtherance of free enterprise and the dissemination of truth.

One of our physicians who has for many years been a professional and civic leader is our immediate past president, my predecessor, C. Paul White. This silver tongued orator has been generous with his helpful counsel and encouragement and has in many ways aided me during the past year. I shall always keep in mind Paul's kindnesses to me.

The Council under the highly capable leadership and guidance of F. Lee Stone has functioned most efficiently during the past year. Council meetings are scheduled for Sundays, yet the members actually begin with committee meetings on the preceding Saturday during the day and evening. Much serious deliberation and many carefully made decisions are the rule. It has been a real pleasure to have attended the many meetings of the Council and to see and hear these unsung heroes of our society at work. To you of the House of Delegates I commend them one and all.

The Secretary-Treasurer, Harold M. Camp, continues to guide and direct the society through its many problems. His background of thirty years of service in this important position is a great asset to our organization. Harold has been most cooperative during the past year and for that and for the help of Frances Zimmer and her staff who so ably serve him in the Monmouth office I am grateful.

The many committees through which so much of the work of the society is accomplished have all rendered able and sincere service. They report to the Council and The Chairman of the Council will furnish you with an annual report of their activities. However, I should like to particularly commend the committees concerned with Postgraduate Education and with Medical Service and Public Relations.

Postgraduate Education programs under the leadership of George A. Hellmuth are becoming huge successes. The meetings offer the best material presented by the top medical men and educators and are proving to be a valuable asset in keeping our members well informed. Dr. Hellmuth has had fine cooperation from local groups which of necessity is important to the success of the sessions. As an example, in Alexander County the Conference was held in late January in Cairo. I saw there all fourteen members of the County Society plus fifty-one more from neighboring counties and from adjacent points in Kentucky and Missouri. This naturally spoke well for the efforts of the local society.

The Medical Service and Public Relations Committee has had many problems, all of which have been ably met by the Chairman, Percy E. Hopkins and the members of the committee. An outstanding service of this Committee was the presentation to the State Senatorial Committee on Licensure and Miscellany the facts concerning the Osteopathic bills which had been introduced at the 1953 session of the 68th Illinois General Assembly. Their work was so successful that the Committee of Senators voted to not approve the bills for consideration by the Senate.

The Woman's Auxiliary is a strong component of our great organization and I suggest and urge that we give them hearty and substantial cooperation, so that they may be encouraged in their efforts to lighten our burden. They stand ready and willing to help us — let us never let them down.

To the many who have contributed to the welfare of this great society through devotion to duty and public welfare either as individuals or as Chairmen or as members of committees I am sincerely grateful. I wish it were possible to mention each by name, for the officers alone would be powerless without this volunteer help.

It has been a great honor to be one of the 103 physicians who have been chosen as president of the Illinois State Medical Society in the 113 years of its existence. I retire from the office with mixed emotions — I shall be happy to relinquish the care of the office of President, but I shall be eternally grateful and shall never forget to be thankful to you for the privilege of allowing me to serve in this high office. It has been a great honor and I pray God I have carried it with dignity.

Respectfully submitted,
LEO P. A. SWEENEY, M. D.
President, Illinois State Medical Society.

REPORT OF THE PRESIDENT-ELECT
WILLIS I. LEWIS, HERRIN

The interim between the election of your President-Elect and his taking office can well be called his apprenticeship.

I have enjoyed immensely this past year, my period of indoctrination, so to speak. To my preceptors, Dr. Leo P. A. Sweeney, President; Dr. Lee Stone, Chairman of the Council; all members of the Council; all Committee Chairmen, and, in fact, to every member of the official family of the Illinois State Medical Society, I owe a deep debt of gratitude.

It has been my privilege and good fortune to attend all meetings of the Council during this past year. This has brought me to realize the tremendous amount of work connected with our State Society, and further to appreciate how efficiently this task is carried out by our Council. These meetings have been a great inspiration to me and have developed in me a deep feeling and belief that many members of our State Society, especially County officers, should be accorded the privilege of sitting in on these meetings. Thus,

they too, would come to appreciate and better understand the workings of our fine State Society.

It was my pleasure and high honor to represent our State Society in Pinckneyville last Fall, when that town honored their fine citizen, our own Past President and Illinois' 1953 "Physician of the Year," James Scott Templeton.

Another pleasant and enjoyable duty your President-Elect was called upon to perform was a trip to New York on March 17 thru 19, 1953, to attend a National Health Council meeting. It was then that a hearing was had on the report of the President's Committee for the Nation's Health. There were many implications, in this report, leaning far to the left. Organized medicine was well represented, and, no doubt, did much to thwart or at least challenge Socialism.

I deeply appreciate the honor of having been made your President-Elect with the eventual elevation to the Presidency. I humbly solicit your loyal support and friendly assistance in the year ahead, in carring on the traditionally high standards of our Illinois State Medical Society.

Respectfully submitted,

WILLIS I. LEWIS, M. D.

President-Elect, Illinois State Medical Society.

REPORT OF THE SECRETARY-TREASURER
HAROLD M. CAMP, MONMOUTH

One year ago when this Society was in its regular annual session it seemed quite probable that the Korean War would be over soon. Unfortunately, however, it is still on with no immediate prospect of a change. We have seen many Illinois physicians called to service with armed forces, and many more have received orders to await an early call. Unfortunately, we have seen a number of young physicians locate in various parts of this state, become well established, only to be called to service shortly thereafter.

THE PHYSICIAN PLACEMENT SERVICE

In spite of this situation and with a good many physicians going into service, we have been most fortunate in helping many communities get a physician. There are still many small towns without resident physicians, but it is quite doubtful if they will ever be able to support a well trained physician properly. Recently we had called to our attention a small town where at the turn of the century there were two physicians. Within a radius of ten miles, there were a total of 16 physicians, this in the horse and buggy days. Today this small town has no physician, and within the ten mile radius there are two physicians who cover more territory and see more patients during the year than the 16 did in the old days. With the all-season roads, use of cars, and with modern facilities, we have failed to hear of a single instance where a physician could not become available within a short time even for emergencies.

As a rule, we have a list of more than 100 physicians who desire to locate in Illinois. We send out bulletins each week to the entire list, giving up-to-the-minute requests for additional physicians in various parts of the state. We make a careful study of the needs, not relying on a single statement that additional physicians are needed, unless confirmed by the secretary of the county medical society in which the town in question is located. Our records show that approximately 75 physicians have been assisted in locating in various areas of Illinois.

We have about 100 communities listed, most of them very small towns, where it is insisted that physicians are urgently needed. Many times we learn that there are two or more physicians within a short distance, and if another should locate in the place, he would be used principally in emergencies, or to care for night calls. Most people would go to a nearby larger place, where better facilities would be available, for chronic ailments, special examinations or services. A problem frequently arises at this time when the only physician in a fair sized community is called for service with the armed forces.

Before sending information to inquiring physicians, in addition to information concerning their previous locations, training and other essential data, we invariably ask about their Selective Service status. If they are eligible for service, we urge them to be sure they will not be called in coming months before attempting to locate. We have had several instances where physicians have located and done remarkably well for a year or two, then must give up their practices to enter service. This is a most unfortunate situation, as some of them have added to their office equipment, and have purchased a home in their relatively new location.

We investigate every request for physicians, as too often the information that another physician is needed in a community comes from someone who has a place to rent or sell. Quite recently we received a request for a physician from a business man in one Illinois city, for a small town some 35 miles away, where he owns a home which "would be ideal" as a residence for a physician, and in which he could develop an office. He would be willing to part with this home for some $13,000.00, which in a small town would be quite a financial load for the average physician seeking a location.

It is likewise our policy to insist that the towns needing a physician have a suitable home and office space for the new doctor, before we add the community to our list of prospective locations. A number of them have also accumulated a sum of money placed in a local bank, from which the physician can draw at a low rate of interest, to aid in purchasing equipment, household goods, and perhaps the first payment on the

needed car. One good community recently wrote to us stating that a home and office were available for a doctor, and there would be no rental charge the first year, and not until the practice would justify the additional expense.

We believe our Placement Service is worthy of much time on our part, and it is an excellent public relations medium at a relatively low cost. A letter was received from a young physician a short time ago, who had decided to locate in California, going in with an elderly man desiring to retire, and eventually turning over his practice and equipment to the young man. He thanked us for the courtesies extended to him, and said he had written to several state society placement services, but none of them compared with the material sent from our office. He, together with many physicians on our lists, had been receiving the weekly bulletins, as well as special releases relative to unusual locations recently reported to us.

ILLINOIS HOSPITAL SITUATION

Under the Illinois Hospital Construction Program, known popularly as the Hill-Burton Program, 42 hospital projects have been approved in Illinois, providing a total of 3,348 additional hospital beds. Of these 42 projects, 25 are complete and in operation, while 17 are still under construction. Of the 25 already in operation, 21 are general and chronic disease hospitals, one Tuberculosis Sanitarium, one Public Health Center, one Nurse's Home and one laboratory addition. Of the total of 3,348 beds provided, we find there are:

General Hospitals	2,322
Tuberculosis	120
Chronic Disease	650
Neuromental	142
Nurses Home	114

Although our list is by no means complete, we have information that there are a number of other hospital additions or new facilities under way. At least six of these are new hospitals varying from 40 to 500 beds. During the past six months, a notable example of new construction is the Mendota Community Hospital, built under a "private enterprise" system, and is now operating. Our incomplete list of new hospitals, or those being enlarged, and not under the Hospital Construction Program, totals 17. When complete, these will add materially to the new beds available in Illinois.

At least 15 of these newer hospitals are located in Southern Illinois, where the obvious shortage of hospital beds in recent years was generally recognized. There are but few places in the State of Illinois today, where hospital services cannot be had within a very short period of time. With the young physicians receiving their training under the Joint Student Loan Fund, set up by the Illinois State Medical Society and the Illinois Agricultural Association, it will not be long until quite a number of communities will have more and younger physicians. Unfortunately many of these young men, instead of locating as soon as their internships are completed, must enter service for a minimum of 24 months. We have been informed that there are approximately 52 who have been aided through this joint loan fund, several of whom have completed their internships. Doctor English, in his committee report, will comment in more detail on this subject, and we urge every member of the House of Delegates to read his report carefully.

It is our opinion that there is no serious need for physicians and hospitals in any part of the state.

A. M. A. MEETING IN WASHINGTON

Your Secretary was instructed to go to Washington when the House of Delegates of the A. M. A. met in special session on March 14, 1953. The purpose of the meeting was to consider the proposed presidential recommendation to create a new Department of Health, Education and Welfare, the Secretary to have cabinet status. Under the plan there would be a sub-secretary for each of the three groups, including health. The President of the United States appeared before the assembly to discuss the plan briefly and urged cooperation on the part of organized medicine. He stated emphatically that the words "compulsory" and "socialization" were repulsive to him and as long as he was in office there would be no evidence of either of these.

Following the President's address, Senator Taft discussed the subject in much detail and likewise urged the delegates to approve the proposed plan. Then Congressman Walter Judd, M. D., of Minnesota talked on the subject, and he, too, believed the plan should be approved.

Although admitting that this was not what the A. M. A. had been asking for over a period of some 70 years, it seems to him to be the best that can be obtained at this time. Many legislators are afraid of what might be demanded from other professional groups if a separate department of Health were established, with a physician as its Secretary. After adjournment and reconvening in the early afternoon, the plan was approved by the House of Delegates, although they still insisted that there should be a Federal Department of Health under the direction of a physician as secretary.

NATIONAL HEALTH COUNCIL

On March 18th and 19th Drs. Willis I. Lewis, Harlan English and your Secretary under Council instructions, attended the Annual Meeting of the National Health Council, in New York. The principal subject for discussion during the three days' session, was the consideration of the five volume report of the President's Committee on the Health Needs of the Nation, under the chairmanship of Dr. Paul B. Magnuson. Doctor Magnuson, his Co-Chairman, and several members of the Commission were on the speaker's stand, and after two or three short talks by them, questions were asked by the audience which were

directed to individual members of the Commission.

In the afternoon and all of the following day the group was divided into panels, for panel discussion under specific headings. Physicians present from more than 20 states and members of the A. M. A. staff sat in on each of these panels to give information on the many subjects under discussion. It was the general thought that there is no actual physician shortage in this country, where there are more physicians in proportion to the population than there are in other large nations.

One physician present from Oklahoma stated that he had personally placed $1,000.00 in a bank which would be given to anyone who could give definite proof that anyone in the state desiring medical attention, was unable to receive adequate care. Up to now he stated the money remains in the bank.

We were informed after the meeting, the third day being a closed session for delegates only, that no definite action on the reports was taken. It was quite interesting to note that Volume V of the report, the one giving the recommendations, was the first volume to be distributed. Volumes II and III were not available generally, until the meeting began, although they were distributed freely during the session.

THE WOMAN'S AUXILIARY

Quite a number of us vividly remember the organization of the Woman's Auxiliary to the Illinois State Medical Society, during the annual meeting held in Moline in 1927. A preliminary organization was under way before that session ended, and by the end of the next fiscal year, it was a going concern. This year the Auxiliary is celebrating its Silver Anniversary.

We should all pay tribute to this fine organization on this occasion. The Auxiliary has done much to aid this Society and its members in many ways. As was expressed to your Secretary at the A. M. A. meeting in Washington, which preceded our annual meeting in 1927, the lady informed us that two years previously she knew but little concerning the trials and tribulations of her distinguished husband. She knew her husband was a busy man and worked long hours, too often unable to be home for dinner, and missed many functions which they had planned to attend. She said if she needed a new coat, she could go to a store, purchase one and have it charged to the family account. However, at that time she did not realize what one elaborate purchase on her part might mean to the husband, and they had been married for many years.

This lady then joined the Auxiliary in Philadelphia, and soon knew plenty about the work of her husband and other members of the medical profession. She knew of the troubles the profession as a whole were encountering, for even then many in this country were longing for the type of medical care that was being given in many countries under government control. When we first met this fine lady, she was Organization Chairman for the Woman's Auxiliary to the American Medical Association, and she was anxious to see an Auxiliary organized in Illinois. If you should be curious, we might state that the lady was Mrs. W. Wayne Babcock, whose husband was then head of the Department of Surgery at Temple University.

In 1939, Dr. Walter B. Donaldson, Secretary of the Pennsylvania State Medical Society, came before the Council of the Illinois State Medical Society to tell of the operation of the Medical Benevolence Fund in that Society, which had then been operating some 35 years. They had accumulated the sum of something like $175,000.00, and even though they had some 39 beneficiaries with the maximum grant $50.00 per month, they did not need to touch the principal, but paid all benefits from the interest received from their investments.

That however, cannot be done today with current relatively low interest rates on the type of securities which may be purchased with "trust funds." Dr. Donaldson informed us that the Woman's Auxiliary in his state had subscribed approximately $35,000.00 to their Benevolence Fund. This seems quite interesting to us, for actually that is approximately the amount that the Woman's Auxiliary to the Illinois State Medical Society has added to our own Medical Benevolence Fund during the past 12 years. As has been the case in Pennsylvania, medical benevolence is the number one project in Illinois, for the Auxiliary.

We sincerely hope that by the time this fine organization celebrates its golden anniversary, there will be but few wives of physicians in Illinois who are not enrolled on its membership roster.

MEDICAL PUBLIC RELATIONS

We have recently looked over the minutes of the Council of the Illinois State Medical Society from its organization in 1902, until the present time. That Council not actually realizing it is now starting the second half century of activities. We find that early in the present century, the Council established a Speakers Bureau, enlisting speakers willing to go before many groups to tell what the medical profession was doing to help them. This was public relations.

As early as that time, physicians were urged to pay more attention to their citizenship responsibilities and become interested in all projects which would make their community a better place to live. We recently found a list of physicians in the middle west who were mayors, township supervisors and even postmasters, along with many other political or civic responsibilities. These lists were prepared in the middle "70's" and were published in a medical journal of that period.

We find that the Lay Educational Committee, organized in 1923, was set up to improve the relations between physicians and their work and the laity. Speakers Bureaus were set up to enlist speakers to go before any type of groups or organizations to tell them about health, or discuss any subject pertaining to disease and methods of prevention, according to the desire of the individual group. Some years later

this Committee became the Educational Committee, which has operated continuously since its formation.

About 18 years ago the Committee on Medical Economics was developed and the principal object was to study various economic subjects pertaining to health and medical care, make studies of existing conditions, care of wards of the state, etc., and in addition submit an article on some popular economic subject for publication in each issue of the Illinois Medical Journal.

A few years ago in keeping with most other organizations, the Committee on Medical Service and Public Relations was formed, and one of its functions was the selection of a Public Relations Counsel to aid this Society, and its 92 component units in maintaining good public relations. Mr. James C. Leary was employed as its Director, and he receives his orders directly from the committee, which in turn regularly seeks the advice and orders of the Council.

Mr. Leary has been very active in this work, and constantly desires the cooperation of all county societies, and is anxious to learn their problems and render all possible assistance in their correction. For the first time at an annual meeting, the Council authorized the setting up of a Public Relations Dinner session to be held on Thursday evening, May 21, at the Hotel Sherman. More information relative to the plans and program will be available at the registration desk.

THE SECRETARY'S OFFICE

The clerical force at the Monmouth office has been conducting the regular routine prescribed by the Council. We have been sending out material for Mr. Neal, as Secretary of the Committee on Medical Service and Public Relations, and during the biennial legislative session, these duties are considerably multiplied.

The office has assisted materially in publicizing the Postgraduate Conferences. About two weeks prior to each of the conferences, letters are sent to physicians in the surrounding area, frequently some 700 to 900 physicians, telling them of the conference, the speakers and subjects and urging them to mark the date on the calendar, and arrange to be present.

One week before each conference, we send this same group the official program, and a return post card to be returned to the Secretary of the host society, to better enable him to make the necessary local arrangements. Your Secretary with two members of his staff are present at these conferences conducting the registration, handing out badges, and selling dinner tickets for the evening session. No registration fee has ever been charged for these conferences, and the Committee on Postgraduate Service is indeed to be congratulated for the series held in recent months.

A short time ago the Council authorized the purchase of a new duplicating machine in the Monmouth office, as the one which had seen much service over a period of some 12 years could not properly be repaired. Much use of this new equipment has proven to us that we can turn out better copy than ever before. One of the clerical assistants has been working diligently preparing the handbooks for the Woman's Auxiliary House of Delegates. Fifty pages were required for the material submitted to the office.

We have likewise had the Secretary's "NEWSLETTER" mimeographed each month, and this has been going out to more than 800 on the current mailing list. We are frequently asked what is necessary to receive this publication, and we invariably state that any member of this Society desiring to be placed on the regular mailing list should send their name and address to us and they will be receiving the Newsletter regularly. From the many letters of commendation being received, we believe that this newsy letter is quite popular, and it is frequently quoted in quite a number of Society bulletins and medical journals.

Although your Secretary regularly proofs all copy and submits some copy for the NEWSLETTER, the responsibility for its regular appearance has been placed in the hands of the Secretary's Executive Assistant, Frances C. Zimmer, who has been the office for more than 17 years.

Jane Zimmer Swanson has been responsible for the operation of our Physician Placement Service, starting this work in March, 1942, under the Procurement and Assignment Service for Physicians, then continuing the service as a Society project since the Procurement and Assignment Service was discontinued. Many letters have been received from physicians who have been aided through this service which leads us to believe all the more that this is a major function of our office. Mrs. Swanson is on her 12 year in the Secretary's office.

We have two other full time clerical assistants in the office, Wanda, C. Ross, the chief accountant who cares for all remittances, makes all credits, issues vouchers in payment of all bills and is responsible for the membership records. She is now on her fourth year. The fourth assistant, Mary R. Ward, has been in the office for more than six years. She heads the mimeographic and power equipment department. She has charge of the maintenance of the stencils both for the Society and the Committee on Medical Service and Public Relations. These latter stencils are used for state-wide mailings for John W. Neal. Among her duties is the service rendered to the Postgraduate Education Committee.

Your Secretary has been most fortunate in having capable assistants on duty at his office and one more desires to publicly thank his efficient helpers for their fine cooperation in his endeavors.

THE ANNUAL MEETING

The Council of the State Society authorized a four day meeting in 1953 rather than the three day sessions held in the past. The Secretary's office, therefore, has made the necessary changes.

Section meetings are scheduled for all day Tuesday,

May 19, and also on Wednesday morning, May 20. The other groups meeting with us also have their meetings either on Tuesday or Wednesday morning.

General Assemblies will be held Wednesday afternoon, and all day Thursday and Friday.

The House of Delegates will have THREE meetings this year instead of two. The agenda for these sessions has been arranged so that the second and third meetings can hear the reports of the reference committees which will meet on Wednesday. The schedule set up is:

First meeting—Tuesday afternoon, May 19—3:00 P. M.

Second meeting—Thursday afternoon, May 21—3:00 P. M.

Third meeting—Friday morning, May 22—8:30 A. M.

We are anxious to have the members of the House of Delegates comment on this arrangement—both the four day session and the three meetings of the House itself. All members of the House should arrange to attend all sessions so that each county society in the state will have representation.

The Secretary's Newsletter has been mailed to delegates to the 1952 House, and the names of new representatives of county socities have been added as they are reported to this office. We have tried to keep all members informed of activities during the year, and also of contemplated actions to come before the House at the 1953 session.

Again, in closing this Annual Report of the Secretary, it is our desire to pay tribute to county society officers, and especially the secretaries who have responded so freely to our many requests for information, reports and other essential information desired on short notice. It seems each year that it becomes necessary to ask for more service from the secretaries than ever before, yet we hear no complaints. We want to thank this fine group of officers for their spirit of cooperation with the Secretary's office. We also desire to publicly express our gratitude to the officers of this Society and the Council as a group and its individual members, for the encouragement and assistance given to the Secretary and his office personnel. The Councilors, representing all areas of Illinois, have devoted much time and energy for the best interests of the county socities they represent. They have expended sincere efforts to aid in the improvement of health conditions of the citizenry of this State.

MEMBERSHIP DATA

Since the By-Laws of the Illinois State Medical Society were changed to make membership in the A. M. A. mandatory to hold membership at the county and state levels, there have been only a few who have dropped out of the Society. In our annual report a year ago, we reported the total membership on April 30, 1952 as 9,729.

Added during the year:	
New Members	499
Reinstatements	57
Total added for the year	556
Dropped during the year:	
Died	183
Removals from the state	185
Resigned	17
Non-payment of Dues	193
Expelled	0
Total dropped for the year	578
Membership as of April 30, 1953	9,707

FINANCIAL REPORT OF THE SECRETARY-TREASURER

Receipts from County Societies

Adams	$ 3,960.00	Lee	1,440.00
Alexander	1,185.00	Livingston	1,825.00
Bond	417.50	Logan	1,635.00
Boone	780.00	McDonough	1,085.00
Bureau	2,562.50	McHenry	1,642.50
Carroll	745.00	McLean	5,425.00
Cass	675.00	Macon	585.00
Champaign	7,392.50	Macoupin	1,035.00
Chicago Medical Society	324,730.00	Madison	6,990.00
Christian	1,560.00	Marion	1,785.00
Clark	315.00	Mason	195.00
Clay	565.00	Massac	435.00
Clinton	780.00	Menard	330.00
Coles-Cumberland	4,600.00	Mercer	590.00
Crawford	670.00	Monroe	325.00
DeKalb	2,390.00	Montgomery	1,150.00
DeWitt	130.00	Morgan	2,997.50
Douglas	675.00	Moultrie	630.00
DuPage	8,265.00	Ogle	1,355.00
Edgar	1,020.00	Peoria	11,872.50
Edwards	195.00	Perry	975.00
Effingham	1,085.00	Piatt	715.00
Fayette	520.00	Pike	520.00
Ford	780.00	Pulaski	440.00
Franklin	1,495.00	Randolph	975.00
Fulton	2,025.00	Richland	1,405.00
Gallatin	390.00	Rock Island	8,007.50
Greene	585.00	St. Clair	8,715.00
Hancock	1,260.00	Saline	1,452.50
Henderson	330.00	Sangamon	9,382.50
Henry	1,962.50	Schuyler	325.00
Iroquois	1,512.50	Shelby	760.00
Jackson	2,415.00	Stephenson	1,800.00
Jasper	195.00	Tazewell	2,230.00
Jefferson-Hamilton	1,300.00	Union	1,070.00
Jersey	225.00	Vermilion	180.00
Jo-Daviess	370.00	Wabash	1,175.00
Johnson	195.00	Warren	1,282.50
Kane	14,435.00	Washington	315.00
Kankakee	4,600.00	Wayne	500.00
Knox	2,972.50	White	45.00
Lake	5,952.50	Whiteside	1,510.00
LaSalle	677.50	Will-Grundy	8,745.00
Lawrence	755.00	Williamson	1,192.50
		Winnebago	7,457.50
		Woodford	1,165.00
Total			$515,317.50

General Fund	149,037.50
Benevolence Fund	23,910.00
Educational Fund	128,150.00
A. M. A. Dues	214,220.00
Total	$515,317.50

RECEIPTS AND PAYMENTS
Fiscal Year Ended April 30, 1953

Receipts

Component Societies:		
General Fund	$149,037.50	
Benevolence Fund	23,910.00	
Educational Fund	128,150.00	
American Medical Association Dues	214,220.00	$515,317.50
Subscriptions—Journal		409.56
Advertising—Journal		70,918.20
Exhibits—State Meeting, 1952	514.50	
Exhibits—State Meeting, 1953	7,967.50	8,482.00
Interest on Government Bonds		2,250.00
American Medical Association—Collection Service		2,417.33
Sheridan Trust & Savings Bank—Liquidating Dividend		63.88
A. M. A. Woman's Auxiliary—Refund		356.95
Refunds and Miscellaneous Receipts		230.09
Total Receipts		600,445.51
Cash Balance, May 1, 1952		118,392.60
Total		$718,838.11

Payments

Secretary's Office Expense	$ 32,882.88
Council Expense	14,132.54
American Medical Association Meetings Expense	7,692.91
State Meeting Expense	16,596.07
Legal and General Counsel Expense	500.00
Journal Expense	68,317.19
Educational Committee Expense	21,531.51
State Fair Exhibit	475.35
Chicago Medical Society—Services	656.63
Committee Expenses:	
Advisory—Child Health Service	$ 19.33
Advisory—I. P. A. C.	33.50
Advisory—United Mine Workers	204.74
Archives and Medical History	720.92
Blood Bank	38.80
Cancer Control	54.17
Cardiovascular	253.70
Civil Defense	41.52
Ethical Relations	73.38
Fifty Year Club	581.54
Grievance	29.05
Industrial Health	48.68
Maternal Welfare	632.54
Medical Economics	69.88
Medical Service and Public Relations	31,222.48
Military Affair and Emergency Medical Service	22.75
Nursing	122.36
Nutrition	379.77
Postgraduate	3,877.25
Scientific Service	556.09
Tuberculosis	216.50
V. D. Control	63.95
Woman's Auxiliary	2,327.14
	41,590.04
Social Security Taxes	505.97
State Unemployment Insurance	74.29
Federal Unemployment Insurance	88.02
Refunds and Miscellaneous	55.00
Transfers:	
Benevolence Fund	23,910.00
Educational Fund	128,150.00
A. M. A. Society Dues	214,220.00
	366,280.00
Total Payments	$571,378.40
Cash Balance, April 30, 1953	147,459.71
Total	$718,838.11

Respectfully Submitted, HAROLD M. CAMP, M.D.,
Secretary-Treasurer.

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois

To the Members of the House of Delegates:
Illinois State Medical Society:

CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1953:

Secretary's Office—Dr. Harold M. Camp, Secretary,
Journal Office—Mr. L. E. Malley, Manager,
Educational Committee—Miss Ann Fox, Secretary,
Benevolence Fund—Dr. H. M. Camp, Secretary.

Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society, and were compared with the Secretary's report.

The receipts include amounts received for the Benevolence Fund, A. M. A. Dues, and Educational Fund, which have been transferred or remitted to the several funds.

Journal Advertising receipts have been verified with

the records of the Manager who receives and remits same to your Secretary.

Bond Interest received was compared with interest due on bonds. Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded.

All receipts are recorded by the Secretary and are deposited in the depository bank.

Payments are made by check and are supported by approved vouchers, orders, etc.

The cash balances were reconciled with the statements of the depository banks.

The Society has invested in U. S. Government Bonds, par value of $90,000.00, which are issued in the name of the Society, also 31 and 70/100 shares of common stock of the Chicago and Northwestern Railway Company. These shares were issued in lieu of bonds formerly held. These securities, as well as those belonging to the Benevolence Fund, were inspected by me.

Benevolence Fund:

As of April 30, 1953, the Society had cash on deposit of $77,912.00 and U. S. Government Bonds, par value $100,000.00, in this Fund.

The accounts of the various departments have been well kept and, in my opinion, your Secretary's Financial Report presents the cash transactions for the year.

The Council will be furnished with a detailed audit report, which agrees in totals with your Secretary's Report.

Respectfully submitted, FRED N. SETTERDAHL, *Certified Public Accountant.*

REPORT OF THE CHAIRMAN OF THE COUNCIL
F. LEE STONE, CHICAGO

The past year as Chairman of the Council of the Illinois State Medical Society has been for me a new and varied experience.

I first wish to thank all the councilors for their hearty cooperation and assistance. Without the help that they have so generously given me, the meetings would not have accomplished their objective.

When we take into consideration the number of committees, both constitutional and appointed—more than forty—that we have to consider, the reports of visitors from councilor districts and the other guests, it no longer is astonishing that the council meetings occupy so much time. All of the problems for the year come to this group to be considered, thrashed out and discussed, and dealt with.

While the various committees will make their reports, I should like to commend the Committee on Medical Service and Public Relations. Dr. Percy Hopkins and his committee, with the help of Mr. John Neal and Mr. James Leary have done some very fine work in this year of State Legislature meeting and before the year ends will have made many valuable contributions to the Society.

June 22, 1952. This was the first meeting of the year and was the organizational meeting. I had gone over the various committees with Dr. Harold Camp and at this point I would like to say that it gives me great pleasure in extolling the value and merits of a mind and memory such as he has. He not only knows the counties and the county officers but also knows most of them intimately, being able to give their location as well as their practice. He has been most helpful. I thought in organizing the numerous committees that I should like to contact the previous chairmen, determine their thoughts as to continuing on as chairman and getting their views as to who they would like to have work with them on the committees.

Many of the previous chairmen were willing to continue and were most helpful in forming a working committee. This procedure was carried out in nearly all cases. This then produced the present set-up of committees and the personnel. I then presented the various committees and their membership to the Executive Council, obtaining their approval and thus forming a very workable Council and committees.

There is one committee that I was anxious to form, which is new, and that is the Committee to investigate the Office of the Coroner. This committee is composed of Dr. Edwin Hirsch, Chairman. Dr. Hirsch is the Pathologist at St. Luke's Hospital and is also interested in this subject in connection with the institute of Medicine. This group also has a committee interested in this subject, having had several editorials on the subject.

Next was Dr. Samuel Levinson. He is the Pathologist for the University of Illinois and is also at Henrotin Hospital. I have known Dr. Levinson for many years and have read his papers on the subject. He is without a doubt an authority on the subject of the Coroner's Office—its use and misuse.

Dr. Harlan English was asked to serve in this committee because of his interest in the matter as well as the fact that he is the Councilor of the Danville District and well acquainted with the legislator from there.

Dr. C. Paul White, past president of the Illinois State Medical Society and very active in its affairs for many years. He is from Kewanee and is known to the legislator from that district and is also personally acquainted with the State President of the Illinois Bar Association, it being necessary to cooperate with the lawyers of the state to get any change through and into the legislation of Illinois.

Mr. John Neal, lawyer and a very loyal worker for the Society, was asked to handle the drawing up of the bill, to contact the lawyers and present it or select the individual to present the bill.

The Coroner's Office has not been changed for about one hundred years and many of us feel that it should be subject to closer attention and that is my chief reason for suggesting the committee and appointing of the personnel.

Dr. Everett P. Coleman had agreed to continue as

Chairman of the I. P. A. C. Dr. Coleman is a past president of the Society and so well-versed on the workings of the I. P. A. C. that it would be almost impossible to find anyone more interested and more capable of handling its affairs. His report was short and related to some of the problems that were continually arising in the meetings.

Dr. Coleman also agreed to continue in the capacity of Chairman of the United Mine Workers Health and Welfare Fund. This, Dr. Coleman has also very carefully and thoroughly taken in hand.

Dr. Harold Camp presented his report as Secretary and Treasurer. Also presented for the consideration of the Council, the advisability of having a four day meeting in May of 1953. This was discussed and agreed to by the Council.

Dr. George Hellmuth made a report of the activities of his committee, presenting a very extensive and elaborate list of meetings, which will be brought out in his report as Chairman of the Postgraduate Committee.

Dr. Leo P. Sweeney made his report as President of the Society, making several suggestions which were to be carried out.

Dr. Lewis as President-Elect made no report.

Dr. Percy Hopkins presented a report of the Committee on Medical Service and Public Relations.

Also much on the subject of Medical Ethics regarding writings and talks by physicians. Also Television and Radio. Mr. John Neal and Mr. James Leary added to the report.

Dr. Percy Hopkins reported on the contract with the Veterans Administration. It was agreed to renew the contract.

Dr. Jacob Reisch of Springfield was given permission by the Council to represent the Illinois State Medical Society at the State Fair.

Dr. C. Paul White as Councilor-at-Large made a report with suggestions.

The Woman's Auxiliary asked for authorization to continue publishing their bulletin. This was granted.

Thus ended the first meeting of the new Council of the Illinois State Medical Society. As stated before it was an organizational meeting. The new committees were presented and approved. In addition much other business was considered and handled in a very satisfactory manner. We continue to be faced with new and seemingly more difficult problems and situations and as of now, must consider them and solve them, some satisfactorily and others less so.

Members of the Medical Service and Public Relations—helped with the Illinois State Fair at Springfield. Also aiding Dr. J. Reisch of the 5th District. It was agreed that the Illinois State Medical Society made a very good presentation with Mr. Leary's help. The Auxiliary also gave a helping hand for which we wish to thank them.

The Peoria Fair was also represented and Mr. James Leary was very helpful.

Dr. Charles P. Blair reported that the Bureau of Health Education of the A. M. A. would participate with the Illinois State Medical Society to have a TV show Kinoscoped. This was agreed to and I had the pleasure of viewing this show, in association with Dr. George Byfield. At this meeting of the Educational Committee the name of the TV show was changed.

The Committee on the Health Program of the University of Illinois, headed by Dr. Harlan English and composed of Dr. Lundholm and myself, reported on the visit to Champaign and their interview with President Stoddard. The meeting was held in the office of President Stoddard and attended by Provost Coleman R. Griffith and Dr. H. L. Lawder. President Stoddard made several statements but wished to delay a more complete report until the newly appointed Director, Dr. Lester M. Dyke could have a chance to get his department organized and under way. This was agreed to.

The Committee on Cardiovascular Disease reported on a number of problems, especially wishing to act as a liaison between the Chicago Heart Association and the Illinois Heart Association, as well as with the Illinois State Medical Society.

The Committee on Military Affairs was reported on by Dr. Carl Steinhoff.

At this meeting Dr. Roland Cross reported on the polio situation in Illinois. Also on the shortage of the Health Department personnel.

The various councilors made reports which they will again include in their separate reports.

Dr. Van Dellen as associate editor of the State Journal reported on the cover color of the Journal and also on some of the items to be used, such as drug column, society news, society actions on the county level, deaths, etc.

Dr. Harlan English discussed the problem of the so-called "Branch Practice."

Council Meeting October 9, 1952.

At this meeting Dr. Harold Camp reported on the fact that Dr. Roland Cross had been Director of the Illinois Department of Public Health for twelve years and during that time had attended nearly all of the meetings of the Council. Also that Dr. Cross has brought all major problems of the Department to the Council for their consideration. That procedures in his office have not been changed without first presenting the matter to the Council for their consideration and approval.

This is unique as there are only two states where such amiable status exists between the State Health Department and the State Medical Society.

On September 7, 1952 a number of members, including myself, journeyed to Mt. Carroll, Illinois to be present at Mt. Carroll's "Doctors' Day." They included Dr. Leo P. A. Sweeney, President and Dr. James Hutton and Dr. Joseph S. Lundholm. Drs. Sweeney and Hutton gave the principal talks, honoring the three country doctors who have piled up a

total of 167 years of service to their community. The doctors honored on that day were Dr. Rollin B. Rice, 85; Dr. Samuel B. Colehour, 77; and Dr. G. E. Mershon, 78 years of age.

On September 23, 1952, I attended the meeting called in Detroit, regarding the President's Commission on the Health of the Nation. I first attended the dinner held on the 22nd of September, given by the Indiana Medical Association.

The meeting was attended by the Indiana State President, Dr. Wright, Dr. F. C. Nicholas Carter and Mr. James A. Waggener, Executive Secretary of the Indiana State Medical Association. Also present were members of the Michigan State Medical Society, Dr. C. E. Umphrey of Detroit and Mr. William J. Burns, Executive Secretary of the Michigan State Medical Society.

I was glad that I attended this meeting if for no other reason than that some representative from Illinois was there. Dr. English had attended previous meetings in Detroit and had reported to me, so that I had some idea as to what it was all about.

The report of the Commission on Health Needs of the Nation has been taken by many as of little note. The States around us, namely, Indiana, Wisconsin, Michigan and Minnesota have gone all out to comply with the suggestions of the Commission.

As the time allotted was so short, all we could do was to formulate a letter, which we did, with Mr. Neal checking on the legal side. We composed a letter which I read at the meeting in Detroit.

The Commission Chairman was Mr. Walter P. Reuther and the Local Medical Chairman Mr. Kenneth B. Babcock.

Continuing with the Council meeting—Dr. Charles Blair's report from his district on the subject of "Fee-Splitting" and the resolution presented by Dr. F. E. Bollaert of East Moline was presented. This project was presented and approved by the Rock Island County Medical Society.

Dr. John R. Wolff as Chairman of the Medical Economics Committee made a complete report with several recommendations.

Dr. Lundholm reported for the Cancer Control Commission to develop the program of cancer detection in the doctor's office.

Dr. M. M. Hoeltgen, as chairman of the Committee on Nursing, made a detailed report. Also reported on his trip to Kansas City.

The December 14, 1952 meeting was held as usual in the Hotel Sherman.

After the President and President-Elect had given their reports, Dr. Camp gave the Secretary's report, which included his observations at the American Medical Association meeting in Denver, early in December.

Among the interesting items was a resolution condeming the use of felons in research, made by Dr. Harlan English.

There was also a resolution asking that the name of the Grievance Committee be changed to the "Mediation Committee." It was suggested that this be left to local decision in the several states.

The "Fee Splitting" resolution received a considerable amount of attention. The Judicial Council ruled that "Fee Splitting" is unethical under any guise and that separate bills must be rendered.

There will be much said about this matter, as a resolution will no doubt be presented to the House of Delegates on this subject. This subject was presented by Dr. Bollaert at a previous council meeting and is far from settled.

Dr. Camp also read a letter from Governor Stevenson. This letter commended Dr. Roland Cross for his twelve years service in the Illinois State Department of Health. This was unanimously adopted by the council.

A number of councilors attended a meeting in Pinckneyville, honoring Dr. James S. Templeton, the outstanding general practitioner of 1953. Dr. Lewis, our president-elect gave a very inspiring talk and others also said a few words. Dr. Templeton was presented with a watch and a placque. Dr. Edwards, with the help of Mr. Leary made the arrangements for this memorial occasion.

A meeting of the A. M. A. Legislative Committee, at which Dr. Wilson of the Washington office called to get in touch with the members in this area was well attended by the Chicago officers of the Chicago Medical Society and the Illinois State Medical Society.

A report was made on the Joliet Postgraduate meeting which was only fairly well attended in the afternoon and very poorly attended in the evening, although the subject matter was interesting as was the evening program.

The Educational Committee reported on the Television Show and Dr. Blair held a telephone hook-up meeting with all members for a fifteen minute conference, at a total cost of $22.40. A very sizeable savings. The new name of the Health TV show will be "How's Your Health."

The Interprofessional Council is in the process of increasing its activities. We have had several meetings with the committee and we are indebted to Mr. Ralph Carpenter, who is secretary of the council. This group is non-political and is composed of men from the various professions, as Medicine, Dentistry, Pharmacy, Optometry and Veterinary. Mr. Carpenter gave a short talk and at a small meeting we suggested that he consider editing a "Drug Column" for the Journal.

Dr. Limarzi reported for the Scientific Service Committee.

Dr. Hutton gave a report on the History Committee and told of the nearly completed work for the 1850-1900 volume of the Illinois State Medical Society. This was a report of progress.

Dr. Hutton also reported in conjunction with Dr. Harry Hedge on the Editorial Board of the Journal and the Journal Committee.

As Dr. Richard Greening of Chicago has not been able to attend a number of meetings of the Council and stated that he could not attend, it was thought best to replace him. The Chicago group went into conference and selected Dr. George Hellmuth as his replacement to May, 1953.

Dr. E. Coleman reported on the meeting held the day before of the I. P. A. C. This meeting was well attended and was of much interest to the various councilors. This will be brought out in Dr. Coleman's report.

Dr. J. Reisch, councilor for the 5th District discussed the subject of "Branch Practice." This related to the subject of "Fee Splitting" and came up at the A. M. A. meeting in Denver.

The Committee on Scientific Work is a constitutional committee. Its functions and duties are to assume the responsibility of arranging the programs for the Scientific Sessions and for providing all speakers, except the orators, in Medicine and Surgery.

This meeting was held on Sunday, October 26, 1952 at the Hotel Sherman and the arrangements were made for the May meeting of the Society.

At a meeting of the Committee on Tuberculosis Control, Dr. George C. Turner, Chairman, presented several items for the committee to consider. They were composed of amendments to the present laws regarding Public Protection. Mr. John Neal was in attendance and stated he would bring them up at the proper time for possible enactment. The committee was in full attendance, with several additions.

At the last council meeting I had invited Dr. Glenn H. Moore of the Illinois Optometric Association. Dr. Moore is an active member of the Interprofessional Council and gave a talk before the council, thanking the council for its courtesy and asking support of the Interprofessional Council in any legislation that may be pertinent and of interest to the entire group.

Due to the illness of Dr. Lee T. Hoyt of Roseville, Illinois, he requested that we accept the appointment of Dr. Paul A. Dailey to act in his stead as chairman of the Nutrition Committee. We held a meeting in my office in Chicago to discuss the functions of his committee. Dr. Dailey is located in Carrollton, Illinois, in active practice.

In February, the Academy of Forensic Sciences met at the Drake Hotel. The meeting was well attended and the papers were of varied and wide interest to medical men, especially now that we have a committee to investigate the Coroner's office. It might be well to add this group to the above committee.

The committee on Standardization of Laboratory Methods of the Illinois Society of Pathologists of which Dr. Opal Hepler is chairman, met to discuss the manner of setting up standards in the various hospitals. This is a very elaborate program and calls for arranging local points throughout the state where an individual or one or two, in a given area, may be consulted or have a training program for small groups, in the various methods that should be standardized, both as to hospitals and individuals. This meeting was held with the committee and a representative of the Illinois Hospital Association. After this conference Dr. Hepler made her report to the Council and it was accepted.

The January 11, 1953 meeting was held in the usual place and a good attendance was promised. The reason—the Winnebago County Medical Society had sent in a protest, first to Dr. Sweeney, president, and then to Dr. Camp, secretary, suggesting that they felt it was unfair to add $20.00 to the dues, without a hearing. This in spite of the fact that the House of Delegates of the Illinois State Medical Society in the May meeting had passed this measure.

Be that as it may, we suggested that the officers of the Winnebago County Medical Society attend the January Council meeting and that we would be pleased to let them present their objections before the entire Council and other officers of the Society.

The Winnebago Society sent their officers, Dr. Rogers, Ford, Palmer, Canfield and Mr. Thorsen, along with the councilor of the 1st District, Dr. Lundholm. Each member of this society present, spoke after being introduced by Dr. Lundholm. This was followed by a general discussion by other councilors and after a very friendly conference, to which most agreed, the discussion was closed by Dr. Paul White and Dr. Leo Sweeney.

Mrs. Harlan English requested a sum of $600.00 be allocated for the May meeting of the Woman's Auxiliary. This was granted.

Dr. Percy Hopkins' committee had several things to be reported by Mr. Leary and Mr. Neal. Mr. Leary had attended the Michigan State Medical Society Public Relations Conference in Detroit.

Mr. Neal reported that the State Legislature was in the process of formation and that he was getting acquainted with the new members. Also that the Coroner's Commission, under Dr. Hirsch, is working with the Bar Association. Mr. Neal and Mr. Holloway at the A. M. A. are working in conjunction, developing such legislation based on the best parts of acts in other states, as well as in New York City. Dr. Harlan English and Dr. P. White agreed this could be done if the Bar Association would help.

Dr. Charles Blair in his report stated that Miss Ann Fox spends about 80 per cent of her time on the Television Shows and the time being free, of necessity is sometimes not the best. A question has arisen as to the necessity of a revaluation of the committee. This is a matter to be considered.

The question also may be considered as to the overlapping of these two committees—Medical Service and Public Relations and the Educational Committee.

The Educational Committee has asked for and been given the audiograph. We also have an additional girl

in the office at 185 North Wabash Avenue, Chicago, so that some of the extra work may now be completed.

Dr. Greening has been unable to do anything concerning the Medico-Legal Committee so there probably will be nothing to report, on this committee.

Dr. George Hellmuth asked that a member of the Illinois State Medical Society be appointed a member to the Joint Emergency Ambulance Commission. Dr. J. Reisch was appointed and notified.

Dr. Hellmuth reported as Chairman of the Postgraduate Committee, made a very pertinent and informative report on Postgraduate Medical Education. This will be brought out more fully in his own report.

Dr. Coleman gave his usual complete and factual report on the activities of the I. P. A. C. The vitamins and needs for same were discussed by Drs. Hess and Van Dellen.

Dr. Wayne Slaughter reported on the Interprofessional Council and the meeting with Governor-Elect Stratton.

Dr. Turner in his report on Tuberculosis Control, suggested that the Secretary of the Society write to each County Medical Society, recommending the appointment of such a committee, i. e. Tuberculosis Control.

The committee further recommends that a suitable meeting of the chairmen of these committees be held prior to or in conjunction with the annual meeting of the Illinois State Medical Society.

Dr. Fred Muller, Chairman of Committee on Arrangements gave his progress report.

Dr. J. Lundholm, Councilor of the 1st District suggested having a Veterans Administration member attend the Council meetings.

Mr. Thomas Hendricks, Secretary, Council on Medical Service, A. M. A. reported on a proposed meeting planned by the so-called National Council on Family Relations.

Dr. M. M. Hoeltgen, Chairman of the Committee on Nursing, made a detailed report of the Nursing situation and on Nursing School accreditation. Council moved to send Dr. Hoeltgen to Lincoln, Nebraska to attend State Conference on Nursing Problems.

Re Council Meeting held March 8, 1953.

As things began to shape up and members of the various committees gathered, it became apparent the last two days of the Clinical Conference of the Chicago Medical Society, that our Council meeting of March 8th was to be an unusual meeting.

On Saturday, March 7th, Dr. Percy Hopkins called a luncheon meeting of the Public Relations Committee, which was delayed as several members were late in arriving. At this time the Coroner's Committee was holding a meeting with all members present: Dr. E. Hirsch, Dr. Sam Levinson, Dr. Harlan English and Dr. Paul White along with Mr. Neal.

These meetings were followed by the I. P. A. C. meeting and conference with Dr. E. Coleman presiding. After dinner and an excellent discussion of the problems of the I. P. A. C. we returned to the meeting of the Executive Committee, to formulate and draw up the agenda of the Sunday meeting. It was after eleven o'clock when the meeting disbanded to meet with the Council on Sunday morning at 9:00 a. m.

Regardless of the many meetings of the previous day, all were on hand Sunday, March 8th.

The meeting opened with a report by the Secretary, Dr. Harold Camp, regarding the need for a new mimeograph machine. The Finance Committee had on the previous day recommended the purchase of such a machine for the Secretary's Office. This was approved by the Council.

Dr. Leo Sweeney made his report on the many meetings he had attended since our last meeting—such as the A. M. A. Council on Industrial Health, the Stock Yards Branch of the Chicago Medical Society; the dinner of the Military Order of the World Wars, where Admiral Swanson was the guest speaker. Also the Postgraduate Conference at Cairo. This has been reported as an excellent meeting, well attended. This meeting was a gathering of at least five of the most southerly county societies of the sparsely settled area where the doctors make calls, many for long distances and where in this area the Public Relations is of the best, as all patients are taken care of regardless of race or creed.

Dr. Sweeney also reported on the Calumet Branch of the Chicago Medical Society and the Chicago Medical Society Clinical Conference.

The Secretary of the State Society had been notified of hearings on the Magnuson Report, or the President's Committee on the Health of the Nation. This was held in New York on March 18th.

Dr. Sweeney requested that Drs. English, Furey, Lewis and Camp represent the Illinois State Medical Society and that the Society pay their expenses. This was concurred in by the Council.

Dr. Lewis as President-Elect reported on the Cairo meeting and gave high praise to Dr. Baur of Cairo, Secretary of the Alexander County Medical Society. All who attended agreed that this was a fine meeting.

The Committee on Medical Service and Public Relations was reported on by Dr. Hopkins. Several matters of importance have been referred to the Committee for consideration, among the items being new laws dealing with tuberculosis. The Tuberculosis Control Committee and this Committee approved a bill, which provides for the hospitalization of recalcitrant patients, where the Health Officer has reasonable grounds to believe that the patient has Tuberculosis in a considerable form and constitutes a public health menace.

The Council approved this bill as presented.

There is also an associated bill which provides for $300,000 to build an addition of 30 beds to the State Tuberculosis Hospital where the previous mentioned patients may be hospitalized or isolated.

This was not approved by the Council.

Dr. Moore, a member of the Interprofessional Coun-

cil and an outstanding member of the optometrist group, stated that he anticipated that an effort would be made to change the present law, which has to do with optometrists in Illinois.

Mr. Neal reported that so far no effort had been made to introduce such a bill. Mr. Neal also reported that Mr. Spreg had introduced H. B. 32 which will provide that products used in connection with a service will not be taxable, and that we should go on record as approving this act.

The Council approved and went on record as approving H. B. 32.

Dr. Hopkins recommended that Dr. Camp and Mr. Leary arrange for a meeting of the Public Relations Committee chairmen, to be held during the annual meeting in May. The Council approved the suggestion.

The Council approved, at Dr. Hopkins' suggestion, that Mr. Leary be sent to the A. M. A. meeting in New York in June.

Mr. Leary reported that during the week of the Chicago Medical Society Clinical Conference, he had been busy helping with the Public Relations there. Mr. Leary has also been helping Dr. George Hellmuth with the Postgraduate meetings about the State—he having been assigned as Secretary to that Committee. He also related that his connection with the Postgraduate work has given him an opportunity to combine these activities with Public Relations. He again also suggested a meeting during the May Annual Session would be a fine opportunity to get the Public Relations chairmen and the county society officers together.

This meeting of the various county society officers and Public Relations men was discussed by Drs. Sweeney, White, Goodyear and C. Blair. Also Dr. E. Hamilton. A separate meeting from the Secretaries' meetings was thought best and it was suggested that the Interprofessional Council be included with this group, as their work is largely Public Relations.

The activities of the Health Department were reported on by Dr. Roland Cross. Dr. Cross reported on the State's activity in the field of Cancer. This disease is on the increase and he gave some interesting statistics on the number of cases, i. e. 6,666 in 1923 to 14,754 in 1951. Also that the increase in mortality has taken place among people above the 50 year mark.

Dr. Hoeltgen reported as Chairman of the Nursing Committee. This Committee through Dr. Hoeltgen has been doing considerable work on the subject of hospital accreditation. A very controversial subject at this time. The questioning as to whom shall control the nurses training program—the large hospitals with University affiliation or the smaller hospital without University contacts. The question is so important that much study has been given to the problem. It has been thought by many that the smaller hospital with training schools, should not be discouraged because if they are closed or are unable to obtain candidates for training, the nurse source would be curtailed.

After all, the nurses training is to provide care for the patient and this should be the major consideration.

Training for administrative duties by nurses should be in a different category, possibly in a school with University connection. Nurses training for patient care should under no circumstances be curtailed.

Dr. Hoeltgen has attended the meeting here in Chicago as well as in Kansas City, where he attended the 14 state conference on Nursing Problems. In Kansas City the representatives of the group stressed the theme: "care of the patient" with a discussion of the following subjects:

(1) Refresher courses for nurses who have been in retirement and desire to return to active nursing.

(2) Economics.

(3) Personnel of teaching staffs in schools of nursing.

(4) Recruitment.

(5) Curriculum.

(6) Social life provided by nurse training schools.

(7) Influence of Veterans Hospitals.

The primary purpose of the meeting was to improve the care of the sick by a team of three—the hospitals, the nurses and the doctors.

The Illinois State Nurses Assn. will have its state meeting on October 1 to 3, 1953 at the Hotel Sherman.

Dr. O'Neill suggested that the survey of the postgraduate requirements is essential, and the one weakness at this time is to provide an incentive for the men to attend. A survey may come up with some of the answers.

Dr. O'Neill also told of the memorial to Mrs. George A. Kirby. Mrs. Kirby, the wife of our Vice President, passed away after a long and useful period in the Woman's Auxiliary. The form of the memorial has not been decided on. Contributions may be sent to St. Margaret's Hospital, Spring Valley, Bureau County, Illinois, with which she was identified for many years.

Dr. Hellmuth as Councilor of the Third District wished to request a joint meeting of the Chicago Heart Association and the various branch societies of the Chicago Medical Society.

The Ambulance Committee of the Institute of Medicine is working to develop the idea throughout the City that Chicago should have ambulance service.

Dr. Reichert reported on matters of interest to all of us.

(1) The question of interstate shipment of dangerous fireworks. A bill to prohibit the interstate shipment of fireworks has been introduced by Congresswoman Margaret Stitt Church of Illinois. This is H. B. 116 and should be reported.

(2) The gamma globulin situation was discussed. A request from the A. M. A. and the National Research Council, which will have control of the program together with the various state departments of public health, that the members of the profession help in the education of the residents relative to the use of gamma globulin. The use of gamma globulin is limited in value. Various groups do not feel that this is the answer to the problem of polio control.

A motion was approved by the Council as follows:

(1) That publicity be given to the physicians of Illinois concerning the recommendations of the Committee on Gamma Globulin of the National Research Council, and the Subcommittee on Blood of the Office of Defense Mobilization;

(2) That physicians be urged to correct the overemphasis that has been given regarding the role of gamma globulin in the preventive treatment of poliomyelitis.

(3) That the Council support Dr. Cross in his program and urge all members of the Society to cooperate with him in obtaining equitable distribution of available gamma globulin, especially explaining to patients and the public at every opportunity the shortage and limitations of this material.

(4) That Mr. Leary and the Committee on Medical Service and Public Relations be directed to publicize these facts.

Dr. Scatliff reported on the Woman's Auxiliary and the value of the work this group is doing. He also stated that the Auxiliary has made extensive plans for the meeting in May.

Dr. Dailey, as acting Chairman of the Committee on Nutrition, reported that he was arranging a program for the May meeting.

Dr. Hirsch in bring the report of the Committee of the Coroner's Office up to date, stressed the importance of the problems involved. Exchanging our present system for the medical examiner system in Illinois—or at least to incorporate some of the better features in our existing laws.

Mr. Neal explained the plans and method of drawing up this bill for presentation and some of the many hurdles that had to be crossed.

Dr. Fred Muller reported on the Clinical Conference of the Chicago Medical Society and all who attended agreed that it was a grand success.

Dr. Muller also reported on the coming meeting of the Illinois State Medical Society and stated that arrangements had been made for the speaker for the annual dinner.

Dr. Furey reported on the changes in the Constitution and By-Laws of the Illinois State Medical Society and stated that copies of the suggested changes were mailed to all members of the Council. These changes will be presented to the House of Delegates at the May meeting for action.

The Civil Defense Committee's report was presented by Dr. Earl Blair—he in turn presenting Dr. Charles L. Maxwell, State Deputy Director of Civil Defense and General Woodward, head of Civil Defense in Illinois.

Dr. Maxwell is located in the Museum of Science and Industry in Jackson Park and is also a member of the Illinois State Medical Society. He reported on a plan for the state-wide activation, organization and utilization of First-Aid Stations and Improvised Hospitals in the Civil Defense of the State of Illinois. He passed out copies of the plan to the Councilors.

The expense of this undertaking to be borne locally, by the State and matched by Federal funds.

General Woodward re-emphasized the need for Civil Defense preparedness. Also deplored the apathy which existed throughout most areas of the State, as well as the country.

Dr. Cross discussed the proposed plan as outlined and recommended its approval and the Council concurred.

Dr. Hepler made a report for her committee. Dr. Hepler asked for and received approval of the Council for a plan proposed by the Illinois Society of Pathologists.

This plan is to send out standard solutions to the hospitals for an evaluation of the various laboratories in the state.

The results of this procedure would aid in obtaining cooperation of the hospitals and it was suggested that the State Medical Society and the Illinois Hospital Association announce this program in their Journals.

Also the state should be divided into districts, each district having a member of the Society act as a consultant to the hospitals. The purpose being to help the hospitals give better laboratory service to their patients.

The consultant of each district would work out a program for the hospitals in his district and hold meetings with the various technicians from the hospitals in that district.

Dr. Coye Mason reported for the Blood Bank Committee, with a plan to cooperate with Civil Defense and requested the Illinois Society of Blood Banks to develop and furnish the committee with a list of the names of people concerned with the Blood Bank program in the area.

Also to consider the value of a series of talks on stored blood and the indications of danger in blood transfusions when blood is used too much.

The Journal to publish each month a page of items which would emphasize the problems of blood transfusions.

Also to standardize the technique of cross-matching, using the standards of the National Institute of Health.

Dr. C. Blair reported on the problems of the Educational Committee, relative to TV and Radio.

Dr. Limarzi reported on the Scientific Service Committee as to the programs over the radio and also regarding speakers for groups other than County Medical Societies.

County Medical Societies should be requested officially by the Committee to schedule their guest speakers ahead of their business sessions.

It was requested and concurred in by the Council that the I. S. M. S. Committee on Rural Medical Care be given the sum of $10,000 as of August 1, 1953 to carry on the work of this group. This money is needed to keep up a substantial balance for the Student Loan Fund.

Dr. English reported that at this time there are quite a few boys working under the plan, about 52 in all; two boys are out; four are in their internships, and six are Seniors. It has not cost the Society too much and the plan is a most popular one with the Illinois Agricultural Association.

Dr. Hamilton reported on the National Health Council which was held in New York, March 18 and 19. This was for a review of the Magnuson Report. The Illinois State Medical Society had a good attendance from Chicago and down state and made some headway.

Dr. Hellmuth, reporting for the Postgraduate Committee stated that the Postgraduate program is running along well, the Council on Medical Education and Hospitals of the A. M. A. being of much assistance.

He also suggested a fact-finding survey of the state to determine the best possible procedure with the Postgraduate programs. The funds for the survey to come out of the general fund of the Postgraduate Committee.

Dr. Fullerton, Councilor from the Tenth District reported on the excellence of the Cairo meeting. Also on the booths at the Springfield Fair and suggested that Mr. Leary look into the advisability of considering the Duquoin Fair.

Dr. Coleman made his report for the I. P. A. C., bringing out the many problems that exist because of the increased call for some of the newer and more expensive drugs. This was true in most districts, there being exceptions in the districts where the Chairmen of the local committees were able to handle this subject more or less to the satisfaction of all concerned. Many of the questions were discussed by Drs. Hamilton, English and Montgomery.

Dr. James Hutton reported in conjunction with Dr. Harry Hedge on the Journal Committee and Educational Board, stressing the advertising which had some criticism and asking the Councilors to stimulate the flow of County Society news.

Dr. Hutton reported on the History Committee—the work of the Committee being about 80% completed and securing the Council's approval of making Dr. D. J. Davis, Editor of the new volume of the history of the Illinois State Medical Society from 1850 to 1900.

Dr. Hutton also reported on the Interprofessional Council and the meetings. The committee is doing good work. They are doing something for Medicine.

The American Medical Education Foundation matter was discussed with the report that approximately $180,000 will be turned over to this Foundation.

Dr. W. Newcomb stressed the importance of carrying reports of the I. P. A. C. Committee in the Journal so that all of the doctors in the State might see what is going on in the Committee and notice any changes that may occur.

I would like at this time to express my appreciation of the work that is done at each Council Meeting by Mrs. F. Zimmer. She is always at the meetings and ready to answer any questions pertaining to the motions that are being passed, as well as other questions that arise during the meetings. She is a very valuable employee of the Society and a credit to the Illinois State Medical Society.

The other members of the Monmouth office I have met but have not been in close contact with. I wish to thank them for whatever service they have rendered.

The Chicago office employees should come in for praise and I wish to extend it. They are all hard working and are on the job, doing whatever the various members ask. Thanks for your many kindnesses.

Respectfully submitted, F. LEE STONE, M.D., *Chairman of The Council.*

REPORTS OF COUNCILORS

FIRST DISTRICT
JOSEPH S. LUNDHOLM, ROCKFORD

The First District has been active and progressive during the past year in a number of ways. In June, 1952, Carroll County Medical Society honored three of their Fifty Year Club members with a celebration on the campus of Francis Shimer College in Mt. Carroll, with the entire county and the city of Mt. Carroll cooperating. An excellent program was held and was attended by a large audience.

Lake County Medical Society has developed an excellent and successful blood bank, which is functioning smoothly and is a credit to their Society. Winnebago County Medical Society has also established a blood bank, which is operating smoothly and successfully. Both of these banks supply needed blood to the hospitals in their respective communities, and both are growing steadily, both in importance and in number of subscribers.

The Postgraduate Educational Committee presented an excellent program in Rockford early in March, which drew an attendance of considerably more than one hundred doctors. This program was very ably presented and has drawn high praise.

The Councilor visited the University of Illinois July 31st, 1952 as a member of a committee to contact President George D. Stoddard, investigating and seeking to improve health standards on the campus. He has also worked with Dr. Warren H. Cole on the Cancer Control Committee, which is fostering a plan of making every doctor's office a cancer detection center, thus keeping this type of examination within the ranks of the medical profession and obviating the need of lay-controlled "detection centers."

Respectfully submitted, JOSEPH S. LUNDHOLM, M.D., *Councilor, First District.*

SECOND DISTRICT
JOSEPH T. O'NEILL, OTTAWA

Your Councilor has had a busy and very interesting year. He has attended all Council meetings and has been a member of the Educational Committee and the Journal Committee, and has attended every session of these two committees. By the time this report is read

he will have visited each of the component societies in the Second District.

The Second District has had no new hospitals during the year but an addition is being built at the present time to St. James Hospital at Pontiac and a further addition is contemplated to the New Community Hospital at Mendota. This last hospital, the Mendota Community Hospital, was the subject of a special article in the Illinois Medical Journal of March, 1953.

Your Councilor has found the component societies in good condition with a better attendance record, perhaps, than previous years, and has found very stimulating the discussions with the different societies regarding the business of the State Society. These discussions have convinced your Councilor that most of our colleagues show an awareness of the conditions with which organized medicine is confronted these days. I think this is an extremely healthy attitude.

Your Councilor has appreciated his very cordial reception at all these meetings and wishes to thank the officers and members of the component societies of the Second District for the courteous way in which he has been received. It has been a most interesting year.

Respectfully submitted, JOSEPH T. O'NEILL, M.D., *Councilor, Second District.*

THIRD DISTRICT
F. LEE STONE, GEORGE A. HELLMUTH, RALEIGH C. OLDFIELD, JOHN LESTER REICHERT, ARKELL M. VAUGHN, H. CLOSE HESSELTINE
CHICAGO

The Chicago Medical Society continues to develop new activities and to strengthen programs initiated in former years.

The Central Society, the fifteen Branch Societies and twenty affiliated Specialty Groups have brought the best in medical science and progress to the physicians of Cook County.

DOCTORS' EMERGENCY SERVICE

The Doctors' Emergency Medical Service (formerly known as Committee on Night Calls) in 1952 took care of 1,989 emergency calls. A recent survey of cases that had been taken care of by the Doctors Emergency Service showed that all seemed very happy with the service rendered. The participating physicians on this panel are doing a wonderful job not only in saving lives but in the promotion of good first line public relations with the public.

GRIEVANCE COMMITTEE

In the past year, the Grievance Committee of the Chicago Medical Society has handled 209 complaints. About 20 doctors were called in and 26 complainants and the cases were settled satisfactorily. A few cases required additional investigation. Most of the complaints were due to misunderstanding and were settled without the necessity of calling in the doctor and complainant. In some cases the Committee recommended an adjustment in fees and a friendly settlement was reached. Three doctors were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct. A very small proportion of the number of complaints received represents justifiable grievances against physicians.

EMERGENCY MEDICAL SERVICE

Under the able leadership of Dr. Earl H. Blair, the Emergency Medical Service is in the process of orienting the profession and educating the public in the problems of civil defense.

THE COMMITTEE TO INVESTIGATE AND CONSIDER INFORMAL CHARGES OF UNETHICAL CONDUCT

The committee has been very active throughout the year considering all cases which have come up before it and referring considerable work to the Ethical Relations Committee.

ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee has been active and has met problems as they were presented.

MEDICAL SERVICE

Since the fall elections, the duties of the Medical Service Committee have been lessened. The committee is available at all times to handle any problems which might fall within its jurisdiction.

CLINICAL CONFERENCE

The Annual Clinical Conference of the Chicago Medical Society has become one of the outstanding series of programs, demonstrations, discussions, scientific exhibits and commercial displays of the country. The ninth conference held in the Palmer House, Chicago, March 3-6, 1953, was an outstanding success. Dr. Lowell T. Coggeshall and his Committee had a program filled with attractive topics and speakers. The capacity crowds at the clinical demonstrations proved their popularity and interest. The attendance also gave evidence of the appeal of the entire program to the local, state and out-of-state doctors. Two thousand three hundred and ninety (2,390) Chicago physicians and 763 (out-of-city physicians registered their attendance, a total of 3,153 doctors. Allied professionals and others increased the attendance to 5,560. Mrs. Esther Fraser and Mrs. Helen Ludwig with others of the Chicago Medical Society office attended to many of the essential details of organization in preparation of the conference and during the actual session. They deserve a full measure of credit for the success of these meetings.

The effective cooperation of the various members of the Executive Committee of the Chicago Medical Society in publicity, general arrangements including the dinner, registration and the work of those responsible for preparing the program enabled uninterrupted precision in the actual progress of the Conference. They take great satisfaction in accomplishing a constructive service to the Chicago Medical Society as a group and to the many doctors of this organization.

Those who served on this Committee are:

Registration Committee—Dr. F. Lee Stone, Dr. E. V. McCarthy, Dr. E. T. McEnery.

Committee on Arrangements—Dr. Fred H. Muller, Dr. Walter C. Bornemeier.

Program Commmittee—Dr. Lowell T. Coggeshall, Dr. Warren H. Cole, Dr. J. J. Moore, Dr. Harry Oberhelman, Dr. Willard O. Thompson.

Scientific Exhibits—Dr. Norris J. Heckel.

Dinner Committee—Dr. Percy E. Hopkins, Dr. Maurice M. Hoeltgen.

Publicity—Dr. H. Kenneth Scatliff.

Technical Exhibits—Mr. George Braun.

Chairman—Dr. Edwin F. Hirsch.

PRESS RELATIONS

The Press Relations Committee is actively working in the Chicago Medical Society to develop a code of cooperation with the various media which provide information.

TUBERCULOSIS

For a detailed report on tuberculosis in Chicago and the state see the Report of the Tuberculosis Committee by Dr. Turner.

The 67th General Assembly enacted into law a bill permitting tuberculosis boards to hospitalize their patients in adjoining counties or even adjoining states. Under this the Municipal Tuberculosis Sanitarium was placing some of its patients in Oak Forest. However, the attorney general ruled that the law did not apply to Chicago and so this practice had to be stopped. This resulted in depriving Chicago of several hundred thousand dollars from the state subsidy fund. The tuberculosis program was crippled to that extent.

Mayor Kennelly appointed a general coordinating committee composed of representatives of labor, the Civic Federation, the Association of Commerce, the City Council, the state legislature, the women, the Municipal Tuberculosis Sanitarium, the Suburban Sanatorium District, the county institutions, the Chicago Medical Society and the Institute of Medicine. This creates a wider interest in the eradication of tuberculosis and makes it much more of a general community problem. A subcommittee from this committee joined with one from the Chicago Medical Society and the Eradication Committee to study the legislative requirements of the next biennium. The ideas so far developed are as follows:

1. To create a tuberculosis commission to study the various tuberculosis laws in the state and recommend to the next legislature more efficient ways of handling the tuberculosis problem.

2. To raise the Municipal Sanitarium's pegged levy from its $5,250,000 to $5,700,000 and allow its board to hospitalize patients in other counties or other states.

The state hospital in the West Side Medical Center will soon be opened providing about 400 beds for Chicago patients.

CHILD HEALTH

The Child Health Committee has continued to be active in the growing Chicago School Health Program. The following significant developments have occurred in the past year:

The personnel of the Bureau of Health Services of the Chicago Public Schools has been increased by the addition of seven nurse-teachers, making a total of twenty-four. The hearing and vision program has been materially increased as to personnel and funds. To date vision and hearing screening has been introduced into over 300 of the 400 elementary schools. Physical examinations are increasing in number and are being done largely in physicians' offices. An evaluation of this program for the first half of 1952 showed that of about 10,000 examinations performed, only about 500 were done in clinics, the rest having been done by physicians on a private patient basis. The Committee is working actively to make clinics available to eligible families for this important health examination. The ineffective summer round-up type of examination done in the school no longer exists in Chicago Public Schools.

It is to the principle of solving school health problems on the local level that the Chicago plan owes most of its growing national prominence. This principle is carried out through the local school health councils. A member of the Chicago Medical Society plays an important role on each of these councils. To date sixteen physicians have been appointed. They include:

Schools	*Medical Advisors*
Hawthorne	Jerome Weil, M.D.
Mitchell	Nino M. Pelletieri, M.D.
Cook	Helen Heinen, M.D.
Oglesby	Helen Heinen, M.D.
Phil Sheridan	Matthew Lewison, M.D.
Chase	Adolph J. Jaroszcz, M.D.
Von Humbolt	J. M. Goldberger, M.D.
Trumbull	Sol Ditkowsky, M.D.
Williams	Oliver W. Crawford, M.D.
Sulivan	Marvin Nierenberg, M.D.
Mann	Robert Keeley, M.D.
May	J. D. Halpert, M.D.
Peabody	J. A. Petrone, M.D.
Tennyson	J. H. Barnes, M.D.
Oakenwald	Edward W. Beasley, M.D.
Gale	John M. Reichert, M.D.
Dewey	Hugo Stanka, M.D.

The Committee, acting as an advisory group to the Bureau of Health Services, has developed a number of technical procedures and policies vital to the continued growth of the Program.

While the physical development of the Program has been most satisfactory, this year is noteworthy because it marks the general acceptance by the school system and the public of a new philosophy of health in the Schools for which this committee has been working for the past seven years. We can be proud of this accomplishment, but we must remember that it is only the beginning, and that the continued support of all physicians is essential to the continued growth of the program.

Gamma Globulin

The Council of the Illinois State Medical Society is working with Dr. Roland Cross, Director of the Department of Public Health, in insuring an equitable

allocation of gamma globulin in the treatment of measles, infectious hepatitis and poliomyelitis. The controversial nature of this serum especially as to its use in poliomyelitis poses a problem which at this writing has not been solved. The Council earnestly asks that all Illinois physicians cooperate with Dr. Cross in what will be a very difficult situation.

ILLINOIS MEDICAL SERVICE (BLUE SHIELD) BLUE CROSS

During the past year continued progress has been made by the two non-profit prepayment plans with headquarters in Chicago, namely Blue Cross Plan for Hospital Care and the Blue Shield Plan of Illinois Medical Service.

The Blue Cross Plan for Hospital Care with headquarters in Chicago paid hospitals $28,273,455 in 1952 and closed the year with a membership of 2,029,669. Passing the membership mark of 2 million constituted a milestone in Blue Cross history and was the occasion for considerable publicity, the 2 millionth member being an employee of the Shell Oil Company in Wood River, Illinois. An important development leading up to this was the discontinuance of operation in southern Illinois of the St. Louis Blue Cross Plan, so that members in 40 counties in southern Illinois had the opportunity to transfer to the Blue Cross Plan with headquarters in Chicago. Hence, this Plan now serves residents of 93 counties in Illinois.

During the year 273,219 members received hospital benefits. Reserves at the close of the year were $2,415,075. The operating expense was 9.94% and 2% of income was charged to reserve for future hospital care. This means that out of every dollar of income a little over 88 cents was paid to hospitals.

The Blue Shield Plan of Illinois Medical Service is now operating in 97 counties and at the end of 1952 had a membership of 790,486. This means an increase of 206,050 members during the past year. 85,710 cases were paid $2,806,622 indicating an eminently sound financial status. Of total income, operating expenses were 11.58%. An average of over 7,500 members a month are now receiving Blue Shield benefits, which indicates payments to physicians of about $400,000 per month. Since its inception the dues paid by Blue Shield members have remained the same in spite of an appreciable increase in benefits paid.

POSTGRADUATE COURSES

The Chicago Medical Society held two postgraduate courses during the weeks of September 29-October 3 and October 6-10, 1952, at the LaSalle Hotel. The first course given was "Cardiovascular and Renal Diseases" and the second course, "Diseases of the Gastrointestinal Tract, Liver and Pancreas."

The postgraduate courses were started in 1947. They are open to physicians in good standing in their county and provincial medical societies. Registration for these courses has been very high in the past. The 1952 courses were attended by physicians in 18 states and Canada.

Books containing abstracts of all papers were given to those attending and have proved to be very helpful and so much in demand that it is planned to give similar books to those taking the 1953 courses.

In the fall of 1953 a course in "Hematology and Cardiology" will be given the week of November 9-13 and a course in "Obstetrics and Gynecology" during the week of November 16-20 at the Sheraton Hotel. It is hoped that a large number of physicians from Cook County and the rest of the State will avail themselves of the opportunity to attend the 1953 postgraduate courses.

PUBLIC RELATIONS

The Public Relations Committee has made a complete survey of its responsibilities and finds that practically all of the suggestions made by the Public Relations Department of the American Medical Association are now being carried out. The Committee recognizes the necessity for close cooperation with the Press Relations Committee of the Society and has officially extended its offer and desire to cooperate closely with that committee in any way which might be useful to them. It should also be noted that they have appointed a representative to the Medical Service and Public Relations Committee of the State Society, thus integrating the entire medical public relations program at the state level.

WOMAN'S AUXILIARY ACTIVITIES

The Woman's Auxiliary to the Chicago Medical Society has shown to you appreciation of the help the Chicago Medical Society gave them in 1951-53. Their first official duty, as an Auxiliary, was to serve as the County hostess group to the A. M. A. Auxiliary in June, 1952. In summer of 1952, their Legislative and Public Relations Chairmen worked out plans for a concerted Get-Out-The-Vote Campaign. Dr. Eugene T. McEnery encouraged the Auxiliary to continue in getting the "people to vote."

On November 11, an enthusiastic audience heard Mrs. Mary Breckinridge, Founder of the Frontier Nursing Service of Kentucky. All Branches participated in making their Annual Public Relations and Nurse Recruitment program. The Blackstone's Crystal Ballroom was taxed to capacity, and the Press, including the city newspapers and hotel publications, gave this meeting unusually good coverage—both before and after the program. Many Branches have instituted Student Nurse Loan Funds or Scholarships in their local hospitals as their contribution to Nurse Recruitment. In the Branch which originated such a plan in two of its local hospitals in November 1949, at least fifteen students have been able to complete their training with this financial assistance.

The Auxiliary was active in helping to defeat in Committee Senate Bills 73, 74, 75.

Plans are well formulated for a philanthropic luncheon party, commemorating the Auxiliary's Twenty-Fifth Anniversary on April 30 in the Gold Coast Room of the Drake Hotel. Proceeds of the part will be donated to the American Medical Education Founda-

tion and the State Benevolence Fund. The Auxiliary has contributed previously $2,990.00 to the Benevolence Fund.

VETERANS COMMITTEE

The Committee discussed the Military Veterans Organization which was formed in the western states on the objections of Public Law 779. The Chicago Medical Society Veterans Committee discussed the proposals of this other organization and found that the recommendations made had already been sent forward as recommendations of the State Advisory Committee and the American Medical Association. They found that it was not necessary to take any definite action in reviewing the proposals of the Military Veterans Organization. The Committee has endorsed the recommendations of the Veterans Organizations in lowering of physical standards of individuals to be taken into service under Public Law 779, and recommended that all in Priority 3 should serve if they were able to practice medicine.

Respectfully submitted, RALEIGH C. OLDFIELD, M.D., JOHN L. REICHERT, M.D., GEORGE A. HELLMUTH, M.D., H. CLOSE HESSELTINE, M.D., ARKELL M. VAUGHN, M.D., F. LEE STONE, M.D., *Councilors, Third District.*

FOURTH DISTRICT
CHARLES P. BLAIR, MONMOUTH

Affairs in the 4th District this year have proceeded with the tempo usual for the past few years. There have been, in several local units, various vexing items, such as problems of unethical conduct, public relations, Illinois Public Aid Commission problems, mal-practice suits, etc., etc. There have been also many pleasing events and planned activities that have more than offset the vexing problems and have kept the "budget" of local Societies and the District as a whole in the blue.

The problems of unethical conduct for the most part have been settled very amicably and yet the "culprit" has thoroughly understood his position. He has profited thereby to the betterment also of his Society's deportment.

Public Relations have gained considerably in the abstract during the past year in the District. The physicians have interested themselves outside the ivory tower and have in increasing numbers interested their activities in various local civic affairs.

An item vexing local Societies has been the work of adjusting their members to the work of the Illinois Public Aid Commission. Generally, the Societies have been able through their local Advisory Committees to iron out misunderstanding and establish good relations with Illinois Public Aid Commission and have rendered good care to their patients and have suffered no pecuniary loss. However, one of our County Societies has refused to arbitrate their own problems and thus leaving the solution to the State Advisory Committee have been quite unhappy in many instances. And again the fact is hereby well established, that, a good functioning Advisory Committee will maintain good treatment for the patients involved and at the same time maintain the physician's interest both professional and pecuniary.

Another item "vexing" us in this District has been mal-practice suits. For the first time in many years such suits have occurred. In two instances the suits were concluded after most detailed trials. They established in the evidence most conclusively the fact that physicians are at all times considerate primarily of the patient's welfare. And that they conduct their treatment entirely with this in mind. These suits have definitely elevated the respect which the physician receives from his fellow citizens.

The meetings of the County Societies have been held quite regularly and attendance has been improved. In general the Scientific programs have been of a higher nature and have been pretty firm postgraduate timber in the effect on their participants.

The local units of this District, as well as the individual members have been most kind and helpful to their Councilor. More individual members have presented their questions or problems in person to this Councilor than in any previous years. This has been very gratifying and we hope has accomplished influence for "good" in the respective Societies.

It has been a pleasure to attend the sessions of the Council and to be active as a member of several Committees.

It has been a great pleasure to be associated with the members of the Council and to assist in their deliberations and decisions.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Councilor, Fourth District.*

FIFTH DISTRICT
JACOB E. REISCH, SPRINGFIELD

Medical affairs and activity in the Fifth Councilor District during the past year have gone forward in a constructive and progressive manner. Most of the county societies, with the exception of the smaller ones, have held regular meetings for both business and scientific programs. No serious incidents have occurred to disrupt the unity and cooperation of the physicians of this area.

Marked interest and activity, both on the part of physicians individually and collectively as society actions, took place during the summer and fall in connection with the election campaign. This district can point with pride to a marked increase in physician participation in civic responsibilities. The non-partisan "get out the vote" campaign was widely emphasized and in many cases augmented by the Woman's Auxiliary. High tribute must be paid to this group for their ever increasing activities. The service they can render to organized medicine is only beginning to be realized.

At the Illinois State Fair in August, an enlarged and unusually attractive exhibit was sponsored by the Illinois State Medical Society and managed by the

Auxiliary of the Sangamon County Medical Society. The Auxiliary has been responsible for the staffing of such a booth for four years. Three impressive exhibits, "Animal Experimentation," Voluntary Prepayment Insurance," and "Quackery," plus three motion pictures, "Wonder Engine of the Body," "Unsuspected," and "A Stitch in Time," shown continuously through the day, were obtained from the American Medical Association. The intent of this exhibit to present to all classes of people both organized medicine's service and the individual physician's importance was apparently quite successful, as evidenced by the constant crowding of the booth. Many thousands of pieces of literature were distributed.

On April 30 a new type of Postgraduate Educational Conference was held in Springfield. The program, consisting of short, concise, and practical topics—fourteen in number—arranged in panel and symposium style, drew a large attendance. All papers stressed diagnosis and therapy. The educational value of such a program was enhanced by a twenty minute direct question and discussion period following each panel. To this meeting, in the interest of increasing interprofessional relations, the local dentists and druggists were invited.

The Illinois physicians' contributions to the American Medical Education Foundation, as directed by the House of Delegates in 1952, has been well supported by the majority of physicians in this area. Many of the early misunderstandings concerning this "mandatory donation" were cleared up by the State Secretary's explanatory Newsletters.

Your Councilor has attended all meetings of the State Council, several of the State Postgraduate Conferences and has participated as a speaker on the program of those at Danville and Quincy. He has also served as a member of the Editorial Board of the Illinois Medical Journal, as well as a member of the Constitution and By-Laws and Voluntary Prepayment Plans Committees. In my first year as Councilor I have become increasingly aware of the need for a closer unity among physicians in order to manage their own profession and solve the many problems currently being forced and foisted on medicine as a whole. I hope to expend every possible effort in the future to be one of the many necessary to achieve this goal.

Respectfully submitted, JACOB E. REISCH, M.D., *Councilor, Fifth District.*

SIXTH DISTRICT
WARNER H. NEWCOMB, JACKSONVILLE

The Councilor year opened with a meeting at Quincy where a group from Macon County put on a Public Relations Program, which was well presented, holding the attention of the members. Macon County Public Relations Committee should be held as a model for other County Medical Societies.

Green County was visited in September. The meeting was well attended. The program was on Antibiotics which provoked much discussion with definite benefit to the members.

Pike County Medical Society held a meeting in January with a program presented by the Illinois Public Aid Commission and representatives from Calhoun, Scott and Pike Counties. The program was informative with a definite aid to understanding between the Physicians and the Commission.

The Postgraduate meeting was held at Quincy on March 19th, with the Cook County group putting on the program. The meeting was not so well attended but the program was very excellent.

Respectfully submitted, W. H. NEWCOMB, M.D., *Councilor, Sixth District.*

SEVENTH DISTRICT
ARTHUR F. GOODYEAR, DECATUR

The Seventh Councilor District and its component Societies have had a most active year.

The Macon County Medical Society has been particularly progressive in its Public Relations Program. The Speakers' Program developed by this Society has been most informative through its panel, appearing before P. T. A., Women's Clubs, civic, industrial and labor organizations, also radio programs.

An emergency call system has been established and is meeting with public approval.

The Grievance Committee formed two years ago, has aided a great deal in the relationship with the public, relative to service fees and other problems.

A "Press Code" has been established by local newspapers, the results being highly satisfactory to the Medical Society and press. This code contains forms for emergency reports made in the hospitals, to be released to the newspapers, including follow-up.

An Insurance Committee has been organized and is pioneering a program with the cooperation of representatives of insurance agencies, press, Association of Commerce, industry, labor and social agencies, for the adoption of a simplified program to meet with the varied gradations of income, in order to have reliable and informed insurance coverage.

Inquiries from numerous Societies, not only in Illinois, but all over the country, are being received requesting information about the survey pioneered by the Macon County Medical Society, "What the People Think." A cross-section opinion survey was made in Decatur and Macon County about medical care and the general feeling of people toward the Medical Profession.

Three members of the Macon County Medical Society were given Illinois State Medical Society 50 year awards. It was your Councilor's very pleasant duty, as well as his first official act, to make the presentation of certificates and pins.

Decatur and Macon County Medical Staff, including staff members of the Dental profession, contributed $146,000.00 toward a new wing to be built during the ensuing year. The drive was made for $1,000,000.00, and with the example set by the Physicians and Dentists, it went over the top easily, to the amount, at present, of $1,091,000.00.

The Effingham Hospital at Effingham, Illinois, is rebuilding. This has been made possible by funds from the Hill-Burton Act, plus contributions made not only by the public at large, but many from the Medical Profession throughout the State and Country. The new hospital is expected to be in operation by January 1, 1954.

The Effingham County Medical Society, by unanimous vote, donated from its treasury $250.00, to the American Medical Education Foundation. This was given after all members had paid annual dues in full, including $20.00 from each member to the American Medical Education Foundation.

As Councilor, I am attempting to make an appearance at least once each year, to the County Medical Societies in the Seventh District, as they meet. It has been my privilege to visit the Clinton County Medical Society at Breese, Illinois in December, 1952, at which time I had the good fortune to produce a speaker for them, Dr. George Y. McClure, Pathologist at the Decatur and Macon County Hospital. On March 10th, I visited the Christian County Medical Society at Pana, Illinois and found them to be very alert to the activities and medical problems of the day. My next visit will be with the Marion County Medical Society during the first week of April, at which time the Postgraduate Conference of the Illinois State Medical Society will be given in Centralia. This will be a major meeting and a large attendance is expected.

I have enjoyed the work as Councilor of the Seventh District very much. This is my first annual report, and I am proud of the work being done by the Societies that make up the Seventh Councilor District.

Respectfully submitted, ARTHUR F. GOODYEAR, M.D., *Councilor, Seventh District.*

EIGHTH DISTRICT
HARLAN ENGLISH, DANVILLE

The medical affairs within the Eighth District during the last year have gone forward without any startling developments. The number of physicians in the area has increased. There are a few areas in the District that could stand a physician in rural practice, but the economic situation is such that no younger physicians have appeared. The second basic reason for no younger physicians during this year has been the "Korean incident."

In general, the use of hospital facilities has increased, but the length of stay per patient has decreased. The forty hour week within hospitals has brought to management and the profession and the patient many problems. These are gradually being worked out. They have resulted in increasing costs for hospital care since the bill for labor comprises about 75% of a patient's hospital bill.

Another problem that is presenting itself on the horizon is the future of the smaller schools of nursing. As a result of pressure from some nursing educators, it would appear that the smaller hospital school of nursing is going to have to close before too many more years. Since the armed forces and the veterans are not training any nurses, and since smaller civilian hospitals are being forced out of the nurses training business, it would seem that we will go backwards to a nursing aid type of care for the sick. Some people feel that this is progress and only time will tell whether it is to the best interest of the patient and his care.

The postgraduation education pattern in this district is about the same as in the remainder of the state, and excellent postgraduate programs are planned for Champaign, Mattoon, and Lawrenceville, as well as, the physicians in those regions.

The Vermilion County Medical Society presented to the Joint Committee on Accreditation a proposal whereby the number of staff and medical meetings might be decreased using an excellent postgraduate type of educational program at the county meeting level to take the place of the multiple meetings. The Joint Committee reported that they were studying the recommendation and would have an answer by December, 1953.

The tax-supported type of medical care has increased dollarwise despite the highest incidence of employment in the history of the country. The increasing drug and nursing home care costs lead one to be concerned about the future of a free society being able to pay for many of the luxuries that are attached to the care of Public Assistance recipients. As was predicted by many, the costs of these programs, as soon as they were placed under direct payment to physicians and vendors, has increased quite rapidly and unless some change can be made, there is real ground for fear that the legislature will not approve any further increases.

The Health Improvement Associations in this district have done quite well during the last year, and a representative was chosen from this area of the state to sit on the Blue Shield Board. Many hospital directors inform me that between 40% and 50% of the patients now entering hospitals have a major portion of their bill paid by Blue Cross or some commercial carrier. Such a state represents real progress in the last ten years.

An effort was made to render assistance to all County Societies, their members, and their officers when called upon to do so, and I am proud to say that in our district, despite the large volume of medical service rendered, there have been few cases presented to Grievance Committees that could not be settled amicably.

Respectfully submitted, HARLAN ENGLISH, M.D., *Councilor, Eighth District.*

NINTH DISTRICT
BURTIS E. MONTGOMERY, HARRISBURG

To the Members of The House of Delegates:

The past year has been an active one in the 9th District medically. There have been several new hospitals built and in the process of building. New, modern hospitals have been opened in Fairfield, Mt. Vernon, Carmi, Marion and one in the process of building in Benton. These hospitals have very ma-

terially increased the quality and quantity of medical care in Southern Illinois.

The new Tuberculosis Sanitorium at Mt. Vernon is now running at capacity.

The Medical Profession in Southern Illinois has gone all-out in the past year in its fight against the Socialization of Medicine and the socialistic state. Active interest is being taken by the Woman's Auxiliary in the legislative program of the State.

All county societies of the Ninth district have been functioning well during the past year and no serious problems have arisen.

An excellent Postgraduate Conference was held in Cairo recently. This was in the Tenth District but several attended from the Ninth District.

Your Councilor attended the called meeting of the House of Delegates of the A. M. A. in Washington on March 14th. This was a very interesting session. President Eisenhower and Senator Taft made very interesting talks to the House.

The association with members of the Council and the Medical Profession throughout the State has been a great pleasure to your Councilor during the past year.

Respectfully submitted, B. E. MONTGOMERY, M.D., *Councilor, Ninth District.*

TENTH DISTRICT
WILLARD W. FULLERTON, SPARTA

To the Members of the House of Delegates:

There are many problems that come up before medical societies throughout the course of the year, some of which are not of great magnitude, but demand the attention of the officials of the organization. It was brought before the attention of the Councilor how easy sometimes, it is for a doctor to become a member of the medical organization and how, sometimes it is easy for medical organizations to admit doctors that are not eligible. It has also been brought to my attention how doctors can plead innocent to charges that have been brought against them using ignorance as an excuse. It was brought to the attention of the Council, the necessity of the secretaries and the board of censors of the various county medical societies, to know who is eligible for membership in a medical society. The situation was climaxed when a particular doctor, whether by his own efforts and solicitation, or by ignorance, derived a certain amount of newspaper publicity; then it was discovered that he was not a legal member.

There has been considerable talk and argument about the arrangement with the United Mine Workers and the scale of fees used in dealing with them during the past two or three years. This situation is apparently rather quiet at the present time, as there has been no great amount of complaining from the doctors themselves during the past year.

There is some new building in the district since the last report. St. Elizabeth Hospital, in Belleville, is building a new wing at the present time, which is pretty well along in the framework of the construction, but has a long way to go before completion. The hospital situation in Sparta, Illinois, which has had a proprietary hospital for some seventeen years; now due to the death of the late Dr. C. J. Sutherland, it is now in the hands of the administrator of his estate. The community is to vote on April 28, 1953 to establish a hospital district. An attempt will be made to renovate the building, modernizing it to conform to public health regulations. The community of Sparta will make an attempt to finance their own community hospital without the use of Federal funds. St. Mary's Hospital, in Cairo, is in the process of additional building which is near completion.

The activity in the medical societies, as far as the Councilor of the District is concerned, has been largely routine. I was called in on a discussion in East St. Louis, Illinois on the I. P. A. C. program. I was called in on the discussion previously mentioned, of the problem of medical ethics, of a member, of a man who was an illegal member of Monroe County. I presided over the three postgraduate conferences within the District. The one at Cairo was a tremendous success. The success of the postgraduate conference depends a great deal on the ability of the local committees on arrangements and this was truly demonstrated in the Cairo meeting under the efficient leadership of Dr. Paul Baur and Dr. Ray Comer. It also helps a lot for the Chicago and Monmouth offices to get together on the announcements. The status of postgraduate education is in a state of confusion at present. I am not quite sure that anyone knows what they are doing. I do not mean to be critical of the Postgraduate Committee, but since I am one of the members of this committee, I am willing to accept criticism, but I think surely there is some way to bring it out of a chaotic mess; surely the State Society can give practicing physicians some kind of a postgraduate program and at the same time act as a co-ordinating body of the State as a whole. I think much research needs to be done to determine what type of program of postgraduate education is desired and what is needed.

I wish to express a hearty thank you to the officers, chairmen of committees and the delegates of the District for their fine cooperation during the past year.

Respectfully submitted, WILLARD W. FULLERTON, M. D., *Councilor, Tenth District.*

ELEVENTH DISTRICT
EDWIN S. HAMILTON, KANKAKEE

The Eleventh District is glad to report that the component county societies are active and vigorous in medical affairs. Regular meetings are held and the majority of eligible physicians of the District are members of the society.

A Postgraduate meeting was held in Joliet, Illinois in February. It was an excellent presentation of all phases of Edema and was greatly enjoyed by all present. However, the attendance was not what we expected or desired at such an advantageous location. It has been impossible to determine the exact reason for the low attendance although considerable work has

been done to do so. In April a meeting was held at the Argonne National Laboratory in DuPage where an opportunity was given the medical profession to see the work of the Atomic Laboratory. It was well attended and of great interest to the medical profession.

Your Councilor has attended meetings in most of the county societies and finds that they are doing a good piece of work. He has received cooperation from all the officers of the component county societies. He has been available for consultation during the year. Most of his time has been given to committee work for the Illinois State Medical Society and the American Medical Association.

The ladies of the Woman's Auxiliaries have been active in the past year and the cooperation with the medical profession is splendid.

Your Councilor wishes to thank the officers of the component county societies for their cooperation the past year and the officers of the Illinois State Medical Society as well. He wishes to thank in particular the Secretary's office of the Illinois State Medical Society.

Respectfully submitted, E. S. HAMILTON, M.D., *Councilor, Eleventh District.*

REPORT OF COUNCILOR-AT-LARGE C. PAUL WHITE, KEWANEE

One retires from the Presidency of the Illinois State Medical Society to that of the Councilor-at-Large, in which position he is still a member of the Council and acts as a liaison officer, bringing to the attention of the new administration, those things which seem to be most important during his year of office. Probably one of the best reasons for this office is that it does give an opportunity to cushion the fall of the President as he leaves the strategic position of President to descend to mere oblivion as far as the State organization is concerned, and again becomes a fellow practitioner in the art of healing.

Besides attending the regular Council meetings, it has been my privilege to answer many letters and to help interpret the rules, regulations and policies of the State Society, as made by the House of Delegates and the Board of Councilors.

It has been a pleasure to serve in this capacity. I have had the opportunity to observe the present administration and in retrospect evaluate the services which we are receiving from those that represent us on the executive level.

To Leo P. A. Sweeney, we owe a debt of gratitude for his untiring effort and his sincerity of purpose that he has maintained in his year as our President. To Lee Stone, we can only express admiration for his genteelness, his fairness, and his patience in presiding at the Council meetings. To the other officers and the Councilors, I should like to express my appreciation for their interest, their debate, and their business-like approach in managing the affairs of the Council and the State Society.

Indeed it has been a great year, but one cannot help but bring to your attention that trying times are ahead. In our own legislature there are the bills of the cultists to fight against, while on the national level, those of socialized medicine, as such, may be considered unpopular, yet it is hard to understand how the F. S. A., Federal Security Administration, with all its socialistic measures could become so popular and so big as to grow from a few million dollars to several billion dollars in the last twenty years, and be considered and actually receive cabinet status. What seems opportune today may well be a rope about our neck in future years under a different administration. Thus, we as medical men must ever be alert and as individual citizens take a more active part in making the acquaintance and getting the good will of our congressmen and legislators, who now and in the future, may represent us for they hold it in their hands to make or break the morale of the medical profession.

I have further observed that many of our members do not appreciate the full value of good public relations. Our society has been a leader in this field. Our public relations committee is to be complimented, but we, as Doctors, must take personal responsibility in furnishing "round the clock" service, and adequate medical care to all our patients, regardless of their ability to pay. If we are going to raise our voices against socialization, we must be willing to sacrifice and to practice charity, not alone with our needy patients, but with the institutions which are preparing the men and women who are to follow us.

These are the observations of your Councilor-at-Large, as I leave these three glorious years spent in the service of the Illinois State Medical Society, made possible through your loyal support. I shall return to my private practice with many pleasant memories, and with a firm determination to carry on in organized medicine's fight to maintain its efficiency, stature, and dignity among all peoples.

With a grateful heart to you, my friends, I am C. PAUL WHITE, M.D., *Councilor-at-Large.*

REPORT OF THE EDITORIAL BOARD AND JOURNAL COMMITTEE

The purpose of these two groups is to make the Journal more valuable to the Society. In attempting to do this we have held four joint meetings since the last session of the House of Delegates: July 15 and October 21, 1952, January 20 and April 28, 1953. Several subcommittees have met a number of times to study various questions submitted to them. The results of these deliberations are summarized in the following paragraphs.

It was thought that the Journal might be more attractive if the cover were the same color throughout the year. Red was selected for 1953.

Postal regulation now permit the Journal to be mailed at Mendota instead of Oak Park as in previous years.

The advertisements are carefully scrutinized before

being accepted and are believed to be generally acceptable to the members.

A few criticisms have been reported. In every such instance the critic has refused to specify the particular advertisement to which he objected or to assist the Committee in selecting ones to appear in our pages. The number of advertisers has remained about the same—between 65 and 70—in each issue. Some of these are particularly fine from an artistic standpoint. Some furnish an excellent review of the anatomy of some parts of the body. These have received national acclaim. The amount of advertising carried is about the same as that carried by other Journals, more than some and less than others. The Journal of the American Medical Association, for instance, carries more than we do, that is, a larger percentage of their pages are devoted to advertising.

Because of increased costs of publication it was necessary to increase our rates to advertisers 15 per cent to 20 per cent. This became effective January 1, 1953, or on the termination of contracts after that date.

Every medical society from the American Medical Association to the county level has one thing in common, that is, the difficulty of keeping members informed and interested in the Society's activities. These are carried on through committees, councils, delegates, and so on. Too often only the members of these various groups know what is being done. The Journal is attempting to add its bit to the solution of this problem by instituting a new "Know Your Society" column. It first appeared in the March 1953 number. It is hoped that the county societies will use the column to inform the rest of the state of problems arising in their localities and how they were handled.

In discussing the creation of this column it was pointed out that sometimes resolutions are introduced or the time of the House of Delegates is taken up in discussion based on misinformation or lack of information. The Illinois Public Aid Commission was cited as an example. It was thought that publication of summaries of Dr. Coleman's reports to the Council regarding the Advisory Committee's meeting with representatives of the Illinois Public Aid Commission would be helpful in this respect.

The manuscripts of original articles may contain sufficient material to make them acceptable and yet need considerable rewriting. The Editor and Assistant Editor plead lack of time for this work. So a young lady has been employed for this purpose. She is paid for work done—not a salary.

A good summary is many times all a busy reader needs to know about an article, unless it happens to be of special interest to him. It is hoped that within the next few months all contributors will be persuaded to include a complete summary with every article submitted.

The flood of new drugs produced by the pharmaceutical industry furnishes all physicians with a major problem in trying to keep abreast with new developments and to decide which new drugs to use and which to disregard. The question of establishing a drug column was studied for several months by a committee headed by Dr. O'Neill. It was debated by the entire group from July 1952 to January 1953. The desirability of such a column was not in doubt. There was some apprehension that discussion of a drug in such a column would be misconstrued as an endorsement of it by the Society. There was considerable doubt as to where suitable material could be obtained and whether we could find a contributor who would furnish a continuous supply of material. Fortunately, Mr. Ralph Carpenter, of Carpenter Drug Store, 64 East Adams Street, Secretary of the Interprofessional Council has consented to edit this column. This is subject to the approval of his organization, the Illinois Pharmaceutical Association.

Examples of the subject matter, so far seen, make it clear that no one will get the idea that the Illinois State Medical Society is approving the drugs discussed.

Through Dr. H. Kenneth Scatliff, Chairman of its Advisory Committee, the Woman's Auxiliary has been asked to act as a news gathering agency. The Councilors could be of assistance along this line by persuading the county societies in their districts to send in news more promptly to the Secretary's Office.

The Chairmen wish to express their appreciation of the time and effort given to these matters by every member of the two groups and to the Council for its support, and to Mr. Leary and Mr. Malley who contributed from their special fields. Special mention should be made of the interest and help given by the President, Dr. Sweeney, and the Chairman of the Council, Dr. Stone.

Respectfully submitted, JAMES H. HUTTON, M.D., *Chairman,* JOSIAH J. MOORE, M.D., EDWIN M. MILLER, M.D., JACOB E. REISCH, M.D., JOHN R. WOLFF, M.D., FREDERICK H. FALLS, M.D., RAYMOND W. McNEALY, M.D., EDWARD F. WEBB, M.D., ARKELL M. VAUGHN, M.D., EDWIN F. HIRSCH, M.D., KELLOGG SPEED, M.D., *Editorial Board.* HARRY M. HEDGE, M.D. *Chairman,* R. C. OLDFIELD, M.D., JOSEPH T. O'NEILL, M.D., ALBERT VANDER KLOOT, M.D., JOHN L. REICHERT, M.D., PAUL P. YOUNGBERG, M.D., *Illinois Medical Journal Committee.*

REPORTS OF STANDING COMMITTEES

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

The Committee on Medical Service and Public Relations held four meetings throughout the year ended April 15, 1953; in addition, the chairman spent at least one afternoon a week in the office while Dr. Camp's weekly visit to Chicago also included the public relations office. The committee was consulted by mail on several occasions.

In general, the various duties assigned to this com-

mittee have gone satisfactorily. Unlike most other committees of the society, each with a single subject or field of interest, the work of the Committee on Medical Service and Public Relations overflows into many of the Society's activities. Thus John W. Neal, as general counsel and legislative representative, is often called on to advise other committees along both lines and to give counsel as well as to component societies or even individual members. Similarly, James C. Leary, as director of public relations, is often summoned to sit with other committees, to publicize their work or to give other assistance; his work with county societies is recorded below.

The office of Mr. Leary and Mr. Neal is also a service office for many Society activities, and the close association of their distinct, but often related lines of endeavor, as worked out there over the last year and a half, has proven a valuable one from the standpoint of efficiency and greater service.

Last fall also, it will be recalled, the Council transferred to Mr. Leary that portion of the work of the Postgraduate Education Committee not done by the Monmouth office, meaning the organizational detail of all programs, as outlined in the report of that committee. This takes a great deal of time and keeps our facilities fully occupied, since every program represents many telephone calls and a large correspondence file, on top of the daily routine of the office.

In addition, we have worked jointly on Society problems with the Committee on Medical History, the Journal Committee, the Editorial Board, the Interprofessional Relations Committee, Tuberculosis, A. M. A. arrangements, Rural Health and Blue Cross and Blue Shield on Health Improvement Associations, the Woman's Auxiliary, the Chicago Medical Society's committees on press relations, its Clinical Conference, grievance and ethical relations committees, its committee to investigate informal charges, public relations, and various others, plus many individuals.

The office is also on the receiving end of many phone calls ranging from the serious to the ridiculous, pleas for help and advice, names of specialists, questions about medical fees, or attempts to check up on advice given by physicians where doubt remained in the mind of the patient. To illustrate the range: A doctor called seeking to identify a quotation from an ancient author seen in the C. M. S. office fifteen years ago. (Identified properly through Bartlett.) A mother of five called to know whether it would be good for her children for her to buy a home across the street from a large mental hospital. (Stalled; referred to pediatrician.)

Our office has also worked on common problems with various other organizations, such as the Statewide Committee for the Eradication of Tuberculosis, The Illinois Academy of General Practice, the Illinois and National Societies for Medical Research, the Welfare Council of Metropolitan Chicago, various A. M. A. officers and employees, Kiwanis International, the Illinois Healing Arts Committee, the Interprofessional Committee of Cook County and several others.

In the year preceding April 1, the public relations office prepared, mimeographed and mailed a total of twenty-seven releases, of which seven concerned postgraduate meetings and three rose out of Mr. Neal's work at Springfield.

Complicating the increased demand for service was the loss of two valuable experienced employees, Mrs. Bernice Neifeldt, who left in November to become a housewife, and Miss Rita I. Sherwood, who left early in March to become Mrs. Harold Ralston, wife of a commander in the Navy Dental Corps. They were replaced after a difficult interim by two promising workers, Mrs. Clara Mai Rutherford and Mrs. Julia E. Milner. Both are rapidly acquiring experience with the complexities of medical service and public relations, and the office is gradually returning to its usual efficiency.

We will now turn to a discussion of some of the major problems confronting your committee in the last year.

THE PUBLIC RELATIONS PROGRAM. This is being developed along the lines laid down in our last report in a highly adaptable form. The reasons for insisting on adaptability or flexibility are obvious in the sequence of events of the last two years—the abandonment of our opponents' hope for the wholesale socialization of medicine and the substitution therefor of a piecemeal program which may turn up anywhere and at any time; the change of administration in Washington, the question in many minds as to the intention of the new leaders, the Fair Deal's already initiated campaign to recapture control of Congress in 1954 and of the White House in 1956, the change to Cabinet status of the old Federal Security Agency. The possibility of a disturbance in the domestic economy due to deflation and other factors adds further uncertainty to the outlook, while over all runs the realization that Communism is only the more apparent enemy, that Socialism, disguised as a rather vague liberalism, is at least as sinister and far more insidious, and that we must fight both if we are to survive free.

On the other hand, the next two or four years should be for medicine a time, not only to strengthen our defenses, but to work out a positive program that will make it impossible for our detractors to persuade the public that medicine should be socialized. It is a time, as we have previously pointed out, to take the campaign to the grass roots and win the active cooperation of every county society and individual member. If that can be done, we need only good communications to have a state-wide program that will be as flexible as we need and effective on all fronts.

At the same time, we must be careful not to let our program slip into a rut. If we establish a fixed schedule of activities, the experience of similar groups shows, it tends to become a mechanical minimum, ex-

tremely difficult to change. We do not want that to happen in Illinois.

With all these considerations in mind, the Committee has directed Mr. Leary to continue the program of visiting county societies and talking public relations activity to their officers. We do not hand them a program, but emphasize the need for thinking in terms of public relations and suggest various activities which might prove valuable. But we leave it to the individual local leaders, as the best judges of their own community needs, to select and adapt as they see fit. We are interested in awakening interest and stimulating activity. Mr. Leary has now visited twenty-one of the larger cities throughout the state, some more than once, and in many cases the meetings included representatives from nearby smaller counties. This work is still in progress; it must, in fact, be considered a permanent activity.

To intensify this individual recruitment of all medical men in the public relations program, the Committee, with the approval of the Council, has called a meeting of public relations chairmen of all component county medical societies to be held during the annual meeting. This will be a dinner on the evening of Thursday, May 21. It is our intention through this meeting to stimulate greater activity on the part of our responsible leaders throughout the state and give opportunity to suggest various programs for their consideration in their home areas and to learn what is being done and being planned.

SPEAKERS' BUREAU. The work of the speakers' bureau as a part of the Chicago public relations office activity has declined to a low level, along with public interest in the effort to get a socialized medicine bill through Congress. However, an important part of our program calls for the establishment of speakers' committees to seek and filling speaking assignments in every county society, with the state office aiding by supplying speakers and material on request.

GOVERNMENTAL AND LEGISLATIVE. 1953 is a legislative year in Illinois, and for that reason the activity in this field is now intense. Some forty-odd bills of direct or indirect medical significance have been introduced into the Illinois General Assembly. Of these, by far the most controversial are the osteopathic bills introduced by Senator Clyde C. Trager of Peoria. These bills, which were defeated in committee on March 31, would have permitted an undetermined number of osteopaths to practice medicine and surgery without limitation in Illinois. Similar bills failed to pass the Senate by a very narrow margin in 1951, and it seems likely that the same bills will be offered in future sessions of the legislature.

The groundwork for great improvement in the tuberculosis control laws and facilities of Illinois has been effectively laid in recent legislative sessions, with the active participation and guidance of this Society. Seven bills now pending are aimed at further hastening the day when tuberculosis will be as rare in Illinois as smallpox. Senate Bill No. 221, called the Public Protection Law bill, would permit compulsory hospitalization of open cases of tuberculosis where the victim refuses to cooperate with health authorities and constitutes a real danger to public health. Other pending T. B. bills would: Increase from $3 to $4 per day the amount which the state would pay to local governments whose available funds are insufficient to care for their hospitalized T. B. patients; raise the tax revenues of the Chicago Municipal Tuberculosis Sanitarium by $450,000 during 1954 and 1955; and create a legislative commission to study Illinois tuberculosis problems and recommend appropriate legislation. Dramatic progress has been made in recent years in tuberculosis control, a fact due in no small measure to laws sponsored or supported by the doctors of Illinois.

Within the past year, two situations have developed which have had important effects upon the profession's relations with our new law makers. The Krebiozen episode, as it pertains to the University of Illinois, is now the subject of a stormy, confused and protracted legislative inquiry. The legislative committee is supposed to report its findings to the legislature by early June, so that any legislative action deemed warranted can be taken before the General Assembly's final adjournment on June 30. But since little has yet been accomplished to date in five full days of hearings, it seems problematical whether the committee can even conclude its investigation, let alone draw a report, within the time available.

Another widely publicized controversy which has had legislative repercussions is the campaign undertaken by the American College of Surgeons against "fee-splitting, unnecessary surgery, ghost surgery and incompetent surgeons." A bill to make fee-splitting unlawful has been introduced into the Illinois Senate (S. B. 381). Penalty upon conviction would be suspension of license for up to two years. More than twenty states already have laws of this general type, although the wisdom of such legislation is still a matter of conjecture.

Needless to say, newspaper controversies such as these contribute little to a harmonious relationship between the medical profession and the men who write our laws.

With respect to national government and legislative affairs, your Committee has endeavored to cooperate with the American Medical Association. The staff of the Washington office of the A. M. A. conducted an all day regional conference in Chicago on November 7, 1952. Almost all of the members of your committee attended that meeting, and became better acquainted with the people who represent the profession in the nation's capital, as well as the many problems with which they are confronted. The committee received and handled many problems involving federal executive, legislative and military agencies.

In view of the public utterances of the new national administration, both before and since last November's

election, there seems little prospect that national compulsory health insurance as such will receive any serious consideration for some time. Among the topics of primary medical interest at the present time are the creation of the new Department of Health, Education, and Welfare, the proposals to create a new E. M. I. C. program for the dependents of military personnel and the proposed extension of the "Doctors' Draft" law. Medicine's facilities for dealing with these and related problems are undoubtedly stronger now than ever before.

OTHER ACTIVITIES. At the risk of lengthening this report unduly with detailed data which devolve on Mr. Leary and Mr. Neal, we would like to touch on on a few by way of illustration.

Service to County Societies. Under the able direction of H. Kenneth Scatliff, M.D., chairman of the publicity committee for the 1953 Clinical Conference of the Chicago Medical Society, Mr. Leary handled the public education phase of the meeting. He prepared and distriblted widely throughout the state seven releases based on papers delivered during the four days of the conference. Several of the releases scored heavily with the press association and were carried nation-wide, while the local newspapers throughout the state and radio and television news casters used them frequently. He and Mr. Neal have been called to sit in with numerous committees of the Chicago Medical Society,—including for Mr. Neal its committee to investigate informal charges of unethical conduct and its ethical relations and grievance committees, and for Mr. Leary its press relations, tuberculosis control, Suburban Cook County tuberculosis advisory committee and others. Mr. Leary, at the direction of the officers of the society, handled the distribution of statements issued in the name of the society on various important issues which have arisen. He attends the monthly meetings of the Council of the society to be available for such service.

THE OUTSTANDING GENERAL PRACTITIONER. Dr. James S. Templeton of Pinckneyville, Perry County was named outstanding general practitioner for 1953 and his name and biography were submitted to the trustees of the American Medical Association as our candidate for the national designation. While he did not win the latter title, he received wide publicity through the material gathered, written and distributed from our office, including an appearance on Ralph Edwards' national television show, "This Is Your Life."

As we pointed out last year, we are hopeful that some of the larger cities, especially Chicago, will also present candidates for this honor. The outstanding general practitioner need not be from a rural community and the G. P's of Chicago, Peoria, Rockford or other cities are just as worthy of the honor as those from the small towns. Perhaps with a new idea, Illinois could repeat its feat of 1949 when it won the national honor title with Dr. Andy Hall of Mt. Vernon.

THE WOMAN'S AUXILIARY. This Committee, recognizing the value of the Woman's Auxiliary to the Illinois State Medical Society in its designated work, has authorized both Mr. Neal and Mr. Leary to give them any assistance they ask in their program. Both have spent considerable time in the last year in helping to arrange programs, obtain speakers and advising on publicity, while the facilities of the office have been made available to the ladies on several occasions.

THE ILLINOIS STATE FAIR. Again last year the Committee helped stage an educational exhibit of medical material at the Illinois State Fair, with the active cooperation of Jacob E. Reisch, M.D., of Springfield, Councilor of the fifth district. The Council cooperated by making additional funds available. The exhibit was regarded as highly successful and plans were immediately begun for a better one next year.

THE INTERPROFESSIONAL COUNCIL. Both Mr. Neal and Mr. Leary have spent considerable time, under the direction of Wayne B. Slaughter, M.D., of Chicago, chairman, in helping in the formation and activation of this group. It consists now, of our own Society, the Illinois State Dental Society, the Illinois Pharmaceutical Association, the Illinois Optometric Association, and the Illinois Veterinary Medical Society. The Illinois State Nurses' Association has not yet joined and the Illinois Chiropodists' Society has made application which is now under consideration.

A constitution has been drafted and approved by the governing bodies of each component group and it has been incorporated with the assistance of Mr. Neal and attorneys representing the other state organizations. Mr. Leary has written considerable material for promotion and publicity purposes, including an article which appeared in the Illinois Medical Journal.

This organization draws together some 20,000 members of the various healing arts professions, together with their families and friends, in a powerful group which has great public relations potential. Its program calls for joint social and scientific meetings in every major community throughout the state and for common action for the public welfare in any problem involving health. We commend it to the attention of all members of the Council and to officers of local county societies.

THE HEALTH IMPROVEMENT ASSOCIATIONS. These are county organizations set up by Blue Cross and Blue Shield to bring the discrete population of rural areas together in groups which then become eligible for hospital and medical care insurance. They also function as local health councils. They are now organized into a statewide group. At the direction of the Committee and with the approval of the Council, Mr. Leary has worked with these groups since their beginning three years ago. He summed up their story and indicated their valuable contribution to public welfare in an article published in a recent issue of the Illinois Medical Journal.

Again we commend this program to every county medical society for their work in spreading the gospel of low cost voluntary prepayment insurance and of constant improvement in the health standards of every part of the state.

It has been a busy year; we look forward to a busier one.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* EDWIN S. HAMILTON, M.D., ELMER V. McCARTHY, M.D., EVERETT P. COLEMAN, M.D., NORRIS J. HECKEL, M.D., *Ex-Officio,* LEO P. A. SWEENEY, M.D., HAROLD M. CAMP, M.D., *Advisory,* MR. JOHN W. NEAL, MR. JAMES C. LEARY, *Committee on Medical Service and Public Relations.*

MEDICO-LEGAL COMMITTEE

There were no cases of medico-legal nature presented to the committee during the 1952-53 year.

Therefore no meetings were held during this period.

Respectfully submitted, R. T. GREENING, M.D., *Chairman,* PLINY R. BLODGETT, M.D., F. E. BIHSS, M.D., DARWIN B. POND, M.D., RALPH McREYNOLDS, M.D., *Medico-Legal Committee.*

COMMITTEE ON ARCHIVES

The members of your Committee on Archives have met several times during the past year with the Committee on Medical History and have been active in assisting in the preparation of Volume II of the History of Medical Practice in Illinois. The Committee has discussed methods of arousing interest in collecting and preserving material concerning past and present medical history in our State. Many interesting articles and documents have never been collected and may be lost or destroyed if no provision is made for their preservation. Such material will be of great interest and importance in many ways to members of the medical profession, and will be very necessary in the preparation of future volumes of Medical History.

Your Committee hopes to have the assistance of the officers and members of the various county and other Medical Societies in carrying out this work. All societies will soon be notified concerning plans made by the Committee for the coming year.

Respectfully submitted, TOM KIRKWOOD, M.D., *Chairman,* J. J. MOORE, M.D., *Secretary,* E. H. WELD, M.D., DAVID J. DAVIS, M.D., *Committee on Archives.*

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Illinois continues to be represented by five medical schools, all of which are located in the city of Chicago. The Universities of Chicago, Northwestern, Illinois and Loyola have schools of medicine. The Chicago Medical School operates without a University affiliation.

The total number of students in residencies at these five medical schools is 2,061, of whom 1,112 claim residence in Illinois. This June the medical schools of Illinois will graduate 504. Of these 236 are residents of Illinois and many can be expected to practice in this state. In general then it may be said that approximately fifty per cent of students trained in Illinois medical schools come from Illinois homes and to a large extent may be expected to remain in Illinois after graduation. Two of the medical schools administer to student bodies of over 500 while the other three have student bodies in the neighborhood of 300.

Students in Residencies in Illinois Medical Schools

School	*Total in Resident*	*Total in Residence from Illinois*
Northwestern University	517	200
University of Chicago	281	74
University of Illinois	651	633
Chicago Medical School	276	71
Stritch School of Medicine of Loyola University	336	174
Total	2,061	1,112

Medical curriculum is still considered in terms of basic science and clinical teaching. The basic sciences are still largely crowded into the first two years. In order to carry on this basic teaching, the medical schools employ 210 full time and 65 part time teachers, which means about one full time basic science teacher to each ten students. Actually the number of basic science teachers varies from one to fifteen in one school to one to four in another.

While full time teachers are not new in the basic sciences, their appearance and rapid increase in the clinical years has marked an outstanding change in the trend of medical education. Thus one is astounded to learn that there are 181 full time clinical teachers in Illinois Medical Schools. These five medical schools present a varied picture, ranging from some schools with only three or four full time clinical teachers to one school that has all full time clinical teachers. The trend is definite and each year will see more and more full time teachers. In addition to full time clinical teachers, the medical schools still have large part time clinical faculties. Thus the four Illinois medical schools utilizing part time clinical faculties list 2,155 in this category, or more than one part time teacher to a student.

The study of the faculty brings out some interesting facts. The trend to full time clinical teachers implies the need for increased research facilities and an increase in the faculty salary budget. Both these items tend to increase the cost of medical education, and, unfortunately, this is occurring at a time when medical schools are finding it difficult to increase or even maintain their financial stability. Money obtained from alumni associations, organized medicine or any other ethical source is welcomed and sorely needed by medical school administrators.

The extremely large and unwieldly voluntary clinical faculties make better reading in school catalogs than

they do effective teaching groups. The voluntary faculty in the past has been an important factor in holding down the cost of medical education. With the advent of clerkship teaching there is less need for the teacher who can devote three or four hours a week to teaching, and more need for teachers who will devote four to six consecutive hours daily. Thus the gradual encroachment of the full time clinical teachers and the gradual elimination in fact, if not in record, of the voluntary faculty. There must also be many excellent teachers lost in these huge voluntary faculties. Some sort of exchange of voluntary teachers among the medical schools might improve deficiencies in certain schools and assure the full and more equitable utilization of teaching abilities.

From figures obtained from four of the Illinois medical schools, it has been deduced that the average yearly cost of educating a medical student is $2,875 and that the student pays only thirty per cent of this, or $862.50. This leaves a yearly deficit of $2,012.50 for each student, to be made up by endowments and donations. It is to help make up this deficit that members of the Illinois State Medical Society have contributed $20 which was paid along with their regular society dues. Either organized medicine leads in this crusade or medical schools will be forced with the choice of accepting government help or closing their doors.

The question of raising school tuition as a means of decreasing the student's liability to the university is not feasible. Figures ranging from twenty per cent to fifty per cent of the student body represent the number of students doing outside work for pay. The average percentage of working students among the five schools is forty per cent. It is obvious that for this forty per cent an increase in tuition would represent a hardship.

The type of outside work performed by medical students is difficult to determine. However, it is estimated by the deans that over fifty per cent of the students who work are employed as externes in hospitals in and about Chicago. Thus there are more than 300 medical students acting in the capacity of externes. The services which externes render to hospitals is useful in maintaining amicable relations with inspecting boards. However, in the return for services rendered, the externe gets almost nothing in the form of instruction. One medical student made the observations that externships give the student an opportunity to play doctor long before he is prepared. Medical schools recognize the externship problem but seem helpless to solve it. So long as there is a shortage of interns, medical students will be in demand as externes.

The medical schools of Illinois use 27 hospitals for teaching, giving each medical school betwen 750 and 1500 beds over which they exert a reasonable control. The Cook County Hospital, while it affords a large amount of clinical material, because of its present administrative set up, does not adapt itself well to the teaching programs envisioned by the schools. To make this institution an effective unit in Illinois medical education, the medical schools must be given authority to organize and manage the services over which they now exercise only nominal control.

Municipal Tuberculosis Sanatorium is not adequately used by the medical schools. Only one school is at present taking advantage of the opportunities offered. Today with tuberculosis dispensaries and tuberculosis sanatoria it is rare indeed for a medical student to encounter, let alone follow, a tuberculous patient.

The Veterans Hospitals are rapidly becoming important cogs in Illinois medical school teaching programs. They have an adequate number of residents and full time attending staffs. Their organization and staff arrangements are favorable for clerkship teaching.

Medical teaching is in a period of transition from the older didactic method to the clinical clerkship. For example, one Illinois school devotes 2,144 hours to clerkship and dispensary and 759 hours to didactic teaching. In all Illinois medical schools there is a definite preponderance of clerkship and dispensary teaching, the most common ration being about three to one.

Clerkship teaching is designed to give the student early and intimate contact with people and diseases. It stimulates student curiosity, encourages logical thinking and permits the application of knowledge previously learned. Instead of studying disease in an abstract manner from a text book, the student learns first hand from a patient. He not only learns the symptoms and signs of the disease, but he is able to observe how the disease may be colored by the patient's social, financial, and psychologic background.

In order to have a clerkship operate successfully, the students must be on the wards at least seven hours a day. During this period they must be under almost constant supervision. Clerkship supervisors are preferably full time teachers, and with each expansion of clerkships, there must be an increase in full time clinical teachers.

Residents can be profitably employed in clerkship teaching. They can act as checkers of clerk's histories and aid in the assignment of patients. Without the residents in teaching hospitals, the number of full time clinical teachers would have to be materially increased. Because of the important role of the resident in the present day teaching plan, medical educators are painfully concerned over the acute shortage of future resident material. This is brought about by the military demand for physicians as soon as they have completed their internship.

Research has become an important function of the medical school. As the number of full time clinical teachers increases, there should be a definite increase in clinical investigation. Research projects are expensive and would soon come to an end if their financial support was solely dependent on the medical schools. Inquiry among Illinois medical schools suggests that the schools supply from 35 to 50 per cent

of the funds used in research. Financial support to medical research in Illinois medical schools is supplied by federal agencies, organized associations and industry. Among the federal agencies supplying material aid are the U. S. Public Health Service, the Army, the Navy, the Air Force and the Atomic Energy Commission. Organized associations, such as the American Cancer Society, the American and Chicago Heart Associations, and various national scientific foundations contribute to the research programs of Illinois medical schools through grants-in-aid. The pharmaceutical houses make up the major industrial concerns that furnish financial aid to medical school research. It seems that, by far, the greatest financial aid to research in Illinois medical schools is that obtained from the federal government.

During the past few years the number of applicants to medical school has gradually decreased. Nevertheless to fill 528 places in the freshman class of Illinois medical schools, 5,519 applicants were processed. This indicates ten applicants for each place in the freshman class of Illinois medical school.

Students are accepted into medical school on the bases of premedical school grades and the results of their performance on an aptitude test. The premedical school grades must range from high C to A. Each student must demonstrate at least an average performance on aptitude tests. These tests are designed to bring out the student's knowledge of society, his knowledge of science, his ability to verbalize, his quantitative ability, or his ability to solve problems, and, lastly, his factual knowledge of science.

Where possible, the student is interviewed by one or more of the admissions committee. About equal stress seems to be placed on premedical grades and the results of the aptitude test. Thus, a student with rather good premedical grades may fail to get into medical school because of his failure to do well in the aptitude test. On the other hand, a student who does well in the aptitude test may be admitted to medical school despite the fact that his premedical grades may only be in the high C level.

According to the deans, the quality of medical students as a whole seems to be gradually improving. Whether this is due to the large number of applicants from which to choose or a more accurate and suitable method of choosing students is hard to evaluate.

HOSPITAL AND MEDICAL CARE INSURANCE

The importance of hospital and medical care insurance as a means of defraying the cost of hospitalization and medical and surgical care has become increasingly important to the doctor practicing medicine today.

The growth of this movement, however, has made it of extreme importance as an economic factor in our daily lives. In Illinois the Blue Cross Plan operates in 101 counties with a total group of 228 hospitals throughout the state participating in the Plan. The total enrollment of Blue Cross members is over 2,000,000 out of which better than 1300 hospital cases arise daily. Blue Cross pays two and a half million dollars every month to Illinois hospitals. Further payments are made to out-of-the-area hospitals through the Blue Cross Inter-Plan Bank.

Blue Cross operation costs have been stabilized at around ten percent. This permits a payment of 88 cents out of every dollar for hospital care of its members and adds two per cent to reserves to take care of demands for payment of future hospital care. Nevertheless, hospital costs have continued to advance during the year. This rate of advance is projected at approximately one per cent per month.

Blue Shield in Illinois now operates in 97 counties having a total of 800,000 members enrolled. Almost 8,000 patients per month received Blue Shield benefits to help them pay for medical care in 1952. Over 6,000 physicians in 97 counties are supporting the Blue Shield Plan. In addition to the millions who are insured under Blue Cross and Blue Shield, there are untold numbers of people who have limited or extensive coverage under the various old line insurance companies.

NURSING

The nursing situation in the state of Illinois presents a serious and complex problem. There are approximately 85 schools of nursing operating at the present time. Among these some twenty nursing schools affiliated with small hospitals face possible closure because of their inability to meet the nursing standards set up by the Committee on Standards of the American Nurses' Association.

The fields of activity for nurses include private duty nursing, hospital nursing, industrial nursing, educational nursing and medical and dental nursing. The estimated need for nurses to supply adequately these needs in Illinois is 31,479 whereas the actual supply is only 17,703 or an actual deficiency of 53.8 per cent. Hospitals in the State of Illinois are at present operating with a 41.6 per cent nursing deficit. This situation slows up operational procedures in all hospitals and indirectly elevates the cost of medical care.

Something must be done to interest young girls in the nursing profession and especially to attract graduates nurses to the hospital care of patients. Industrial nursing, while perhaps more attractive in some ways, does not give the nursing graduate the opportunity to employ her skills to their best advantage. Nurses working in physicians' and dentists' offices find little opportunity to practice the art for which they have been trained.

HOSPITALS

Hospital bed space in downstate Illinois is being effectively utilized. The twenty Hill-Burton type of hospitals have all been placed in operation. Thus far there is no evidence of failure of any community hospitals to fill the need for its services.

The daily cost of hospital care rises largely in proportion to hospital labor costs, which roughly com-

prise two-thirds of the patient's bill. The forty-hour week has increased labor costs.

There is concern regarding the possibility of closure of some twenty schools of nursing. The best of cooperation on the part of everyone will be needed to save the nursing educational plants within Illinois.

At least two downstate communities have, by voluntary subscription, increased their hospital beds or constructed new hospitals.

From the standpoint of availablity, no citizen in Illinois is more than thirty minutes away from good hospital facilities and adequate medical personnel for the direction of treatment.

Illinois physicians have a large responsibility in directing the course of the education of future doctors and nurses. Physicians and their patients' problems in the homes, offices, nursing homes, infirmaries and hospitals of Illinois where medical care is rendered will always need continued study.

GEORGE F. O'BRIEN, M. D., *Chairman,* HARLAN ENGLISH, M.D., KARL L. VEHE, M.D., *Committee on Medical Education and Hospitals.*

COMMITTEE ON MEDICAL BENEVOLENCE

During the year your committee has been busy looking into the misfortunes of many of our friends and fellow physicians, who have become destitute due to ill health, physical disability, and financial losses, and has considered their necessities in order that we may in some way aid them in making their existence less difficult. Many of these unfortunate friends of ours are reluctant to appeal for aid at first, and only do so when the need is an emergency. Often some friend or relative will make the appeal.

During the year we have received about a dozen requests for help from the Benevolence Fund. Immediately we have sent a questionnaire to the one making the request, asking for information pertaining to their over-all situation, with a request that it be returned to the Committee as soon as possible that we may give it early consideration and allocate necessary funds.

At the present time we are mailing checks to 34 persons from the Benevolence Fund, four applications are pending, five recipients have passed away, one has procured employment and withdrawn from receiving funds.

The Benevolence Fund is in excellent condition. The cash reserve is now about $65,000.00. Government bonds in the amount of $100,000.00 are also held by the Committee. The annual outlay is about $17,000.00 a year, or approximately $1,600.00 a month. At the 1952 meeting of the House of Delegates, on recommendation of the Committee, the appropriation of $5.00 for this fund was reduced to $2.00 adding to the fund approdimately $18,000.00 a year.

The Committee would be remiss if we did not bring to your attention the fact that this is in reality the 25th anniversary of the Benevolence activity of the Illinois State Medical Society. The late John Nagel, as early as 1928, brought to the attention of the House of Delegates the fact that some of our members were in dire need of financial assistance due to ill health or financial losses and unable because of old age and infirmities to resume practice. It was not until 1940 that a resolution introduced by Dr. Nagel was passed by the House of Delegates, establishing a Committee on Medical Benevolence. The Pennsylvania Medical Society had been operating a like fund for 40 years, and ours was patterned after theirs. At first the funds were by voluntary subscription and contributions from fellow practitioners and friends. This proved unsatisfactory and inadequate to meet the demands; therefore, in 1947 the House of Delegates voted to assess each member $5.00 for this fund, this to be added to the dues. With almost 10,000 members at $5.00 each for five years a large reserve was built up; therefore, as previously stated, the amount was reduced to $2.00.

Had it not been for the great interest and wonderful support of the Woman's Auxiliary, both state and county organizations, it would not have been possible to keep the fund in operation at first. Let us pause here to pay homage to the Woman's Auxiliary and its capable leaders, and give them credit for a job well done. They have raised and donated to the Benevolence Fund more than $34,000.00. A history of the Auxiliary and its activities is now in the making by the Auxiliary in celebration of its 25th anniversary.

While most of the appeals for aid are heart rending, there are on occasion ridiculous or even humorous requests, such as a request for a Memorial Glass Window to be placed in a church, requests for burying lots and head stones, and not infrequently requests for funeral expenses.

We are now reconsidering the plight of a former Illinois physician who is now residing in Greece. He left this country because of ill health and poverty, to, as he said, die with his relatives in the old country. Dr. Edwin S. Hamilton, while on a tour for the A. M. A. last summer, went out of his way to visit this doctor in Athens. He reported the situation as destitute and advised that a maximum amount be sent to him. Immediately a check was sent through the American Counsel at Athens. To our great surprise we were informed during the winter that the doctor was in this country and in a local hospital, and that his county medical society was paying the balance over what we were giving to keep him in the hospital. Just recently he has returned to Greece. The Committee is wondering where the funds for his trip to Greece, return to America, and again to Greece came from. We believe a more thorough investigation is necessary in this case. But who will make it?

Another elderly physician, who has been receiving monthly checks for many months, has notified the Secretary that he is no longer in need of our aid or assistance. We are wondering why and how, after all this time, that some effort should not be made for a return of at least some of the funds?

The Committee is of the opinion that a thorough

re-examination of all recipients would be in order and should be done by some physician or friend in the neighborhood or by a commercial investigator.

The Benevolence Fund is in an excellent financial condition at the present time and is increasing at a satisfactory rate yearly. Unless there is a sudden greater demand for benefits the Fund should be able to meet all requests.

Respectfully submitted, ROBERT H. HAYES, M.D., *Chairman,* LEE O. FRECH, M.D., NORMAN L. SHEEHE, M.D., *Committee on Medical Benevolence.*

COMMITTEE ON MEDICAL TESTIMONY

With much gratification we can report the few complaints coming to our committee. The year ending May, 1953, two complaints have been studied. One was quite complicated involving a divorce and child custody. This member of our society meeting with the committee was able to explain with sound reasoning testimony given in court, and was absolved of all blame.

We are hearing but little of ambulance chasing, and personal injury cases seem to provide the most instances in which the medical witness goes astray, either wilfully or innocently. This has become so notable that one of our great Metropolitan dailies has given editorial attention to the matter. Our second complaint was of this character and unfortunately since the x-ray films were not available the committee was unable to take the action which seemed indicated.

At this time it would seem that the work of the committee continues to be useful. Other state societies have written to our good secretary to inquire about its activities, and have been given all the information at hand. We are also pleased to report the continued wholehearted support of the Bar Association.

Respectfully submitted, OSCAR HAWKINSON, M.D., *Chairman,* EVERETT P. COLEMAN, M.D., WALTER L. PALMER, M.D., HARRY A. OBERHELMAN, M.D., EDWARD H. WELD, M.D., ARTHUR F. GOODYEAR, M.D., JOHN H. GILMORE, M.D., MAURICE T. HORSMAN, M.D., *Committee on Medical Testimony.*

GRIEVANCE COMMITTEE

Let it be said to the credit of the medical practice in the State of Illinois that during the year of 1953 there were but six cases referred to the Grievance Committee for consideration. Two of these were holdovers from 1951 which were under investigation by the former committee.

Case No. 1 was a dispute between a doctor and a hospital which was settled without any serious feelings on the part of either party.

Case No. 2 was a case of a family feud which while it brought three doctors into the picture, none of them were in any way responsible for the misunderstanding and were all exonorated.

Case No. 3 was tabled temporarily pending further investigation, as it seemed that there were a number of unjust charges made which should be further examined.

Case No. 4 was one which had already been considered by the state and local Grievance Committee and was a matter of a charge of $50.00 for a case which in the belief of the Committee was thoroughly justified when the service and time of service rendered was taken into consideration. It was closed and filed.

Case No. 5. This was another case of fees and the Committee voted to write the complaining party and explain the decision and close the file.

Case No. 6 was one regarding fees and this also is held over pending further investigation.

Respectfully submitted, HARRY M. HEDGE, M.D., *Chairman,* T. G. KNAPPENBERGER, M.D., EVERETT P. COLEMAN, M.D., E. H. WELD, M.D., PERCY HOPKINS, M.D., C. PAUL WHITE, M.D., *Grievance Committee.*

REPORT OF DELEGATES TO THE A.M.A.

The June 9 to 13, 1952 meeting of the American Medical Association was held in our state. 12,000 physicians and 13,000 guests attended the meeting. It is estimated that 30 million people watched the television programs. It is my considered opinion that Illinois extended the finest in hospitality to the visiting physicians and their friends. The dinner and entertainment for the House of Delegates held at the Hotel Morrison was quite outstanding.

Illinois contribution to the American Medical Education Foundation was quite outstanding. Dr. Furey, in the name of the American College of Radiology, contributed $2,000; the Chicago Medical Society contributed $25,000; Dr. Pfeiffenberger of Alton gave $1,000; and the announcement was made that each member of the Illinois State Medical Society would give $20. Illinois can be duly proud of these accomplishments.

There were 300 exhibits in the scientific session and 1,200 doctors participated in showing these exhibits. Their educational value was tremendous.

The scientific exhibit at the Chicago session exceeded all previous meetings. Many Illinois physicians made this possible. Dr. George Milles, Dr. A. S. Gordon, Dr. L. N. Katz, Dr. J. R. Webster, Dr. Everett Keefer, Dr. Frederick H. Falls, Dr. Georgianna D. Theobald, and Walter G. Maddox were prominent as section representatives.

The speaker of the House made a memorable statement when he said, "The collective responsibility of the American Medical Association is to insure for the American people progressively improved medical service. This will only be as effectively met as the individual physician measures up to his personal responsibility. The question is not: 'What do I get from the A. M. A.?' but 'What can I do to strengthen it'?"

As an indication of what the House of Delegates is—the average age of the members is 59 years and their average length of service 5½ years. At the June session, 14 delegates were seated for the first time and 18 others were in their first year of service. Illinois

was represented by three men on three different reference committees.

President Cline, among other things, pointed out that during the course of the last 20 years medical problems have multiplied and become more complex at all levels. As medical care becomes more prominent in the minds of all of our people, increased complexity results. As public interest has increased in medical care and health matters, *doctors come closer under public scrutiny.* Dr. Cline pointed out that voluntary plans for hospital and medical care fill a great need and render a great service to our people. He suggested that *destructive* criticism and withholding support and cooperation only interfere with the proper development of such voluntary programs and in the end injure the profession. Dr. Cline suggested that grievance committees have gone a long way toward clarifying our code of ethics and our relations with our citizens. President Cline suggested that the committees must be active, easily available, and the public must be informed as to how to reach them. He also observed that the work of such committees can be greatly reduced if the physician will *discuss all aspects* of his service to the patient *at the outset* of the patient's contact with the doctor.

Many bills presented and studied by the 82nd Congress, as well as those bills passed by that Congress were presented and discussed by various physicians.

Among the many other things discussed by the chairman of the Board of Trustees were so-called Health Councils. The trustees defined a Health Council as "a voluntary association of individuals and organizations representative of the entire community which concerns itself with the joint evaluation of health needs and the planning and coordination of health services so as to bring about more effective utilization of the health resources available." Our Illinois Health Improvement Association has certainly conformed with that pattern.

The trustees recommended that the dues remain $25 for 1953, which dues include a subscription to the Journal or any other scientific journal published by the Association.

The trustees suggested and the House agreed that the best way to institute governmental economy in the use of funds and medical manpower is:

(A) To obtain a clear Congressional definition of the extent of the government's responsibility for furnishing medical care with particular reference to the treatment of veterans with non-service connected disabilities and the dependents of service personnel.

(B) To establish a Federal board to control the distribution of beds among the several Federal hospital services, to insure joint planning in the field of hospital construction, and to determine the need and location of proposed new hospitals in the United States.

A lengthy report of progress was made by the Committee on Blood Banks. The committee recommended that County Medical Societies, where possible, cooperate with the Red Cross, but they advised that County Societies should be free to exercise their judgment without undue pressure from outside pleaders. Many other matters were discussed by reference committees of the House of Delegates and report of the Delegates, but their number is so great that I have deliberately selected the highlights, as I saw them, of the June meeting.

The Interim Session of the House of Delegates was held in Denver, Colorado December 2 through 5, 1952. At that meeting, a Texan, Dr. J. M. Travis was selected as the practitioner of the year.

President Louis H. Bauer made some very pertinent observations. He stated that we are increasing the number of physicians percentage-wise at a faster rate than the population is increasing. The fact remains, however, that there are definite shortages of physicians in some areas and that there is a shortage of general practitioners. In Dr. Bauer's opinion, the solution to this problem will not be found in a general increase in the number of physicians, since they would still tend to congregate in cities and take up specialization. Dr. Bauer believes that we must encourage communities to establish facilities for a doctor to practice good medicine in. He recommended that the House of Delegates go on record as approving in principal the development of systems which solve this practitioner problem according to the local needs. This the House did. Dr. Bauer's other and necessary method to a solution was to recommend that our Specialty Boards revise their requirements. The present system results in more men going into specialties than is desirable or economically feasible, and many realize that if they are ever to become specialists they must begin their training immediately on graduation. This system practically prevents a general practitioner from becoming a specialist. Dr. Bauer is of the opinion that the best specialist is one who has a background of general practice. He suggested that the House of Delegates appoint a committee to confer with a committee from the Advisory Board of Medical Specialists to explore the situation and see if some changes can't be made to increase the flow of general practitioners and decrease the flow of specialists.

Dr. Bauer thought, and the entire House of Delegates agreed with him, that the entrance to County Medical Societies is made too easy. He suggested that each new applicant should be admitted after he had familiarized himself with the principles of medical ethics and passed an examination on them. The new applicant should also be told that the maintenance of his membership depends upon his abiding by that code of ethics. If he errs, he should be reprimanded; if he errs again, he should be expelled.

The House concurred in the following recommendation of President Bauer:

(1) That the House of Delegates urge each of our constituent state association to be adamant in disciplining unethical members; (2) That it urge our component County Societies to establish more rigid ethical requirements for membership; (3) That it urge all medical schools to give lectures on medical ethics and

medical traditions using student A. M. A. chapters; (4) That the House go on record as thoroughly disapproving business arrangements between druggists and physicians such as was unearthed in New York. Such recommendations of the House, actively implemented by County and State Societies will let the public know that medicine wants no unethical activity.

An item that took much time and caused much discussion at the Interim Session was the matter of the Veterans Administration operation. Public Law 312 came up for much discussion. That law defines the eligibility of veterans as: (1) those service-connected; (2) Those veterans who must be hospitalized to adjudicate their claims; and (3) Those veterans with non-service connected disabilities who can't afford to pay for their care. There never has been much disagreement about the first two, but the non-service connected cause all of the disagreement. The American Legion representative stated that their group was willing to prevent non-service connected cases, that were chiselers, from receiving treatment in the Veterans Hospitals.

The reference committee felt then, and the House agreed with them, that attempts to change Public Law 312 in December or early in 1953 would be politically impossible, and since the Legion assured us, through their delegated representative, that the state liaison advisory committees would be appointed and every effort would be made to get rid of the chiselers in the non-service connected category. The committee and the House went along with that proposition. It is my opinion that unless much more activity than has been evidenced in the last four months is done in the next two months, this problem will be up again in June, and with the accumulating evidence of abuse with non-service connected disability, I would predict that the House will go on record as advising a change in Public Law 312.

Public Law 779, the so-called Doctor Draft Law, came up for much discussion. The House adopted the proposals of the Medical Society of the State of Pennsylvania, and most all of those proposals are being written into present legislation to extend the so-called Doctor-Draft Bill. One of these recommendations was that greater use of civilian doctors and civilian hospital facilities in the care of military and non-military dependents should be used.

At times protests have been made that medical care is denied certain people because of cost. The House adopted a resolution stating that "The prime object of the medical profession is to serve humanity regardless of reward or financial gain," and with a view of implementing this principle, a number of County Medical Societies have successfully conducted publicized programs offering to provide the services of a physician to anyone unable to pay. The House suggested this be done everywhere.

The Blood Bank Committee submitted many interesting figures concerning what would have to be done with both liquid blood and the proposed gamma globulin program.

Since malpractice insurance rates are variable and increasing, the House instructed the board of trustees to have a bureau make a continuing study of the liability insurance situation.

The Judicial Council reported on many items at the Denver session.

Regarding osteopaths, the council ruled that in the absence of a statement from the osteopaths that they no longer adhere to their original cult theories, the Judicial Council reasserts its opinion that *all voluntary associations* with osteopaths are unethical.

The Judicial Council reports that a so-called privilege tax by hospitals where staff physicians had to pay a certain percentage of their fees to the hospital has been held by a court of law to be contrary to public policy. The council stated that this proposal was clearly a case of fee-splitting with lay organizations which legally could not render professional services in the first place, but which in addition to its already levied regular charges for services had added this privilege tax.

The Judicial Council reported that the increasing number of requests for specific interpretations of the principles of medical ethics causes them to feel that some members don't read or don't consult their County or State Medical Society before sending grievances to the A. M. A. Judicial Council. The Judicial Council reported that many of these requests reflect the age-old desire of physicians to increase their professional income through devious means beyond that of the definite fee for tangible professional services they render.

The Judicial Council again referred to Section 5 of Article 6 of medical ethics which states, "When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission, by whatever term it may be called or under any guise or pretext whatsoever, is unethical." The council stated that this means that the physician who takes a patient over for treatment from another physician should render a bill direct to the patient for such treatment. If it happens to be a surgical case, the doctor referring the case assisting at the operation, gives an anesthetic, or participates in any way in the treatment of the patient, the doctor so participating shall render his own bill directly to the patient, and it shall not be a part of the surgeon's bill.

The Judicial Council announced that it had held many times that when a surgeon renders a bill for his fees, it should not include bills for colleagues who act as assistants or anesthetists, but these colleagues should render their own bills. The Judicial Council also held that associate membership, no matter by what name called, in a clinic, of a physician who lives in another town from that in which the clinic is located, and who sends patients to this clinic for treatment and receives compensation therefor, is practicing unethical medicine,

as well as, the physicians who own the clinic. In fact, a physician who does this and lives in the same town where the clinic operates would be unethical if he practices in this manner. This decision was applied to the appeal of the Springfield Clinic in our state to the Judicial Council. That hearing was held in Denver, and the Judicial Council reaffirmed its previous decision as cited above.

The Judicial Council called attention to the matter of advertising. They reported an increasing tendency for practicing physicians to allow the publication of articles about them or their work in newspapers and magazines, which is distinctly unethical unless the provisions of Section 4 and 5 of Chapter I of the Principles of Medical Ethics are observed. These two sections make generous provisions for ethical use of the press and the radio in spreading *adequately qualified medical and health information* to the public.

The Reference Committee and the House of Delegates provided that the publication of decisions of the Judicial Council is being studied, and the sending of this publication to the secretaries of State and County Medical Societies should lead to a decrease in the number of repeated questions concerning medical ethics and fee-splitting that the council is called upon to answer.

The so-called Iowa Resolution was not presented at Denver and is being presented to various County Medical Societies in various states in the Midwest. From a review of the Judicial Council's decisions, it would seem to me that the "so-called" Iowa Resolution as drawn does not conform to the principles of medical ethics and will not pass appeal to the Judicial Council of the American Medical Association.

A special session of the House of Delegates was held in Washington, D. C. on Saturday, March 14. The special session was addressed by President Eisenhower, Senator Robert Taft, and Representative Walter Judd. After much discussion, a report of the Board of Trustees on Reorganization Plan No. 1 was approved unanimously by the delegates assembled. It was felt by the majority of delegates that this plan 1 providing a special assistant to the secretary for health and medical affairs was a step in the right direction. The Association reserved the right to make recommendations for amendment of the current reorganization plan if the present plan does not result in the proper advancement in and protection of the health of our citizens. President Eisenhower was in total agreement with this position and said if this plan didn't work he'd be back and talk to us again. The president's basic honesty and intense humility impressed everyone who was there.

The above material is presented as the chairman of the delegation's views concerning the more important things that happened in three sessions of the House of Delegates of the American Medical Association within the last twelve months.

Respectfully submitted, HARLAN ENGLISH, M.D., *Chairman, Illinois Delegation, Illinois State Medical Society Delegates to A. M. A.*

REPORTS OF COUNCIL COMMITTEES

ADVISORY COMMITTEE TO THE IPAC

The Report of the Medical Advisory Committee to the Illinois Public Aid Commission is somewhat different this year than it has been in most of the preceding years. There are several reasons for this, due largely to the changes brought about by direct payment. Those of you who have been interested in this program for the past several years may remember back to the days when the fee bill for physicians was less than half of the present fee bill; and when the paper work required for rendering this type of service was much more complicated than it is at the present time. Over the years the paper work has been decreased and the fee schedule has slowly been elevated to the present level. Last year the chief complaint had been the problem incident to the recipient being paid the amount which he was to give to his doctor for medical services and it was thought by many that direct payment would solve this problem. There were a great many others who felt it would bring about more complications than benefits. Probably both viewpoints are correct. At least this present report has to do largely with the complications incident upon direct payment.

Direct payment to physicians has now been in effect since January 1, 1952. While there were many procedural problems in getting the new method of payment into operation, since it was necessary to purchase and rent more accounting and billing machinery and to increase the staff in the Springfield office, most of these difficulties have been worked out satisfactorily and bills are now being paid on the current basis. The only delays in payment are because of errors in billing or because bills are not submitted on a current basis.

Detailed statistics for 1952 are not yet completely available and it is difficult to make accurate comparisons with 1951. However, it is known that medical costs have been mounting steadily since the inauguration of direct payment. The commission estimates that expenditures for medical care have increased from 75 to 80% in the past 18 months. It is impossible to determine how much of the increased cost has been due to the direct payment plan itself. Part of the increase is due to increased rates in most hospitals and because payment is now being made to Cook County Hospital for these recipients. Another significant fact is that more elderly people are living longer and requiring care in nursing homes and institutions. Detailed monthly statistics, will be available soon which will reveal some of the reasons for the increased costs and show for which types of services the expenditures are being made. The following statistics, covering the period from June to December, 1952, show the monthly average payment for medical and nursing care for recipients of Old Age Assistance:

TYPE OF CARE—ONE MONTH AVERAGE FOR 1952—

	Old Age Pension June-December Average	
	Amount	*Percent*
Total	$1,646,322.16	100.00
Nursing Home Care	818,361.39	49.71
Medical Care	827,960.77	50.29
Physician	224,395.01	13.63
Drugs	145,606.89	8.84
Prescribed	77,972.49	4.74
Dispensed	67,634.40	4.10
Hospital	405,821.03	24.65
Other	52,137.83	3.17

The following chart will show the breakdown of this part of the program:

One of the problems has been the increasing cost of drugs. While in many counties the advisory committees have held the cost of prescribed and dispensed drugs down to a minimum, in other places this has not been done and therefore the drug cost is approximating the amount paid physicians for their services. Because of this the commission has thought it necessary to have an advisory committee from the druggists and such a committee has been appointed. This advisory committee had one meeting with the Medical Advisory Committee and from then on has been working on its own. They have made some suggestions as to the cost of drugs which seemed to be a bit too complicated when first introduced so this was later changed. However, the Druggist Advisory Committee is gaining experience and is already taking an important part in the program. In many counties now, the representatives from the druggists sit with the physicians in the monthly meeting of the County Advisory Committee and help in the decisions reached as to the type and cost of the drugs that are used.

The budget for the past two years was based on the anticipated expenses necessary for the number of recipients which it was estimated would need to be served. During this time the number of recipients has steadily diminished but in spite of this the cost of medical care has increased to such a point that the budget has been found to be inadequate for the last three months of the biennium. Moreover, the costs have changed so that the medical expenses which used to be about one million dollars a month have now jumped to practically two million dollars in this same period of time. This accounts to a great extent for the deficiency which will exist before July 1st, the end of the biennium. In September the commission thought there might be a surplus of $3,500,000.00 but by December this had dropped to about $600,000.00 and it is now quite obvious that there will not be enough funds to carry us to the 1st of July. On this account an emergency meeting was held with the Advisory Committee to the IPAC on March 28, 1953 to discuss what might be done as an emergency procedure. A deficiency appropriation had been asked of the legislature which did give enough to cover up the deficiency in the ADC program but not enough to take up the OAA deficiency. In consequence, the only alternative is to prorate the amount left for the last two months, which would be unsatisfactory to all parties concerned, or to attempt to limit the services rendered. It was decided to recommend this to the commission and this is being put into effect at this time. It should be understood that this is an emergency procedure for the sole purpose of making available funds last until the end of the biennium on July 1, 1953.

Rather than reduce the fee bill or to prorate the available funds, it was decided that the only way to make the funds last was to reduce the number of Physician's visits for which the commission would

		Number of Patients	*Number of Visits*	*Av. Number of Visits Patient*	*Total Charges*	*Av. Charges Patient*
I.	Office Visits					
	Regular	16,621	31,221	1.88	$62,123.75	$ 3.74
	Diagnostic	324	368	1.14	1,652.30	5.10
II.	Home Visits					
	Day	10,366	22,082	2.13	65,307.25	6.30
	Night	451	579	1.28	2,257.00	5.00
III.	Hospital Visits	1,464	11,366	7.75	22,062.07	15.07
IV.	Mileage	3,187			6,656.39	2.09
V.	Other Treatment	2,466			11,607.89	4.71
VI.	Surgery	388			22,084.50	56.92
VII.	Drugs dispnsd.	17,077			47,854.37	2.80
VIII.	Injections	3,505			9,788.41	2.79
	Total				251,393.92	
	Credit				205.55	
	Net				251,188.38	

pay, to limit the kinds and cost of drugs which could be provided for recipients, to require prior approval for hospitalization and to make no payments for dentures, hearing aids, artificial limbs or other expensive appliances. There is also to be a retrenchment on all other special services so that a program of economy will not be limited to medical expenditures but will be equally distributed in all other lines.

As a matter of interest and information, there are 1,900,000 unemployed in the entire country who are not OAA recipients and not on this program. It is estimated by the department that with any lessening of war work the number in 1954 will be 3,600,000. This will effect the amount and type of need for IPAC services to the extent that this is reflected in Illinois and may require further appropriations or increases in the budget.

The Governor's budget message provides that not more than $275,000,000 be allowed for Public Assistance for the next biennium. This is somewhat less than was allowed for the last biennium and the estimate the commission has made for the coming two years was that $305,000,000 will be needed to meet the anticipated case load for this period of time. If not more than $275,000,000 is appropriated, the commission is faced with a deficit of $30,000,000. If there is a serious shortage of funds, it will not only be impossible to make any increases in the amount of service rendered but it may be necessary to decrease the amount now being paid for medical care, shelter, food, clothing, and all other branches of service rendered by the Public Aid Commission.

Your committee has worked hard during the past year. Every time the Council has had a meeting it has been preceded by a meeting of your Advisory Committee. During this time we have invited 26 physicians, including chairmen and members of county medical advisory committees, to attend and participate in these meetings. It is felt that this participation has been very valuable since the State Advisory Committee and the Commission itself depend greatly upon the help of local committees for the successful administration of this program. Our relationship with the Public Aid Commission has been a very satisfactory one and because of this we have been able to protect the welfare of the helpless indigent patient by keeping him out of the hands of irregular practitioners with limited skills. We have been able, we feel, to be a part in rendering the highest type of medical care to these public assistance recipients and the expenses of the program have been kept at a minimum, due very largely to the fact that the county advisory committees have been rendering excellent service in regulating the program, in minimizing abuses from all sides and in creating a better understanding between the commission's representatives and the medical profession in respect to the job that has to be done. Your committee feels that it is this type of local service by which the local profession accepts its responsibilities as being good citizens, as well as doctors, that aids in keeping the control of this program in medical hands rather than in the hands of those who would be entirely unfamiliar, and in some respects unsympathetic, to medical problems.

Respectfully submitted, E. P. COLEMAN, M.D., *Chairman,* EDWIN S. HAMILTON, M.D., JULIUS H. HESS, M.D., HARLAN ENGLISH, M.D., B. E. MONTGOMERY, M.D., THEODORE R. VAN DELLEN, M.D., CHARLES P. BLAIR, M.D., *Advisory Committee to the IPAC.*

DR. COLEMAN: I have a supplementary report.

When the report in the handbook was written it was correct as of that date. Since then conditions have changed so rapidly that the report is now obsolete.

Ever since direct payment was instituted we have been notifed regularly by the Commission Staff of the steady increase in medical expenses in public assistance cases. One factor has been the increased number of employees in the Springfield office necessary to do the extra paper work required in reviewing the bills which have been submitted. Another is the cost of the added business equipment needed for this same purpose.

Two main factors in this increased cost of medical care have been: First, the increase in hospital rates, particularly the diagnostic procedures such as laboratory and x-ray examinations. Second, the steady increase in the cost of drugs. The Committee has tried to cooperate in every way it could in attempting to suggest methods whereby these costs might be reduced. It has recommended that the original plan of not allowing payment for costly vitamins excepting in proven cases of vitamin deficiency be continued and that certain very expensive drugs be approved only upon the recommendation of the local advisory committee. In spite of these efforts, cost continued to increase above the original estimates until an estimated surplus of $3,500,000 in September became a deficit in January.

As the cost of prescribed drugs increased the Commission arranged for a State Advisory Committee from the druggists to try and arrange for certain drug standards. It was this druggist's committee which arranged for the approval of only those drugs costing no more than $3.00 per pint, pound, or 100 units. The Medical Advisory Committee was of the impression that these standards, while good in principle from an economic standpoint, might not be very practical because few doctors now use U.S.P. or N.F. We also felt that in cases requiring more expensive drugs, the Medical Advisory Committees could render the necessary approval. This was tried but failed to work out very well because of the added burden placed on the Advisory Committees, and to which many of them objected.

Then in the middle of April, a special meeting of the State Medical Advisory Committee was called (by the I.P.A.C.) and we were told that funds would not be

adequate for medical care to the end of the biennium and that an emergency existed.

Having been a member of this committee for 12 years I recall quite well that each biennium we have been completely or nearly out of funds, and I recall distinctly that deficiency appropriations have been furnished on several occasions. My own feeling or impression was that requests for such appropriation had been rejected. It then seemed that the only way in which the Committee could cooperate was to approve one of these measures to meet this emergency:

1. Reduce fees.
2. Prorate any funds left over for the last month.
3. Curtail or limit services.

The latter seemed the least of three evils and was recommended for the remainder of the biennium.

It then became evident that when the Legislature examined the I.P.A.C.'s estimated needs of $305,000,000, for the next biennium and cut the appropriation to $275,000,000, the same conditions and problems of curtailment might be expected to continue for another two years. This put a different aspect on the matter, especially when it was found that the Commission had not asked for a deficiency appropriation. It was then that your Committee asked for a hearing before the Commission and I, as Chairman, appeared on May 8.

It was explained to the Commission that part at least of the increased length of life of our older population is due to the benefits of modern hospital treatment and to the use of newer and more potent remedies. That these are expensive but that the increased expense is worthwhile and justifiable if relief of suffering and prolongation of life are regarded as desirable objectives.

The Commission was told that while the Advisory Committee and we believe the majority of the profession throughout the state, feel that the costs of medical care should be kept at a minimum, the care of the patient is of paramount importance. Therefore, we asked that in return for every effort on the part of the state and county committees in keeping medical costs down, the Commission return to the local advisory committees the proper right to approve of more expensive drugs when not on the regular drug lists so that medical affairs again be under medical direction. Also that the Commission ask for a deficiency appropriation sufficient to meet the needs of the remainder of the biennium.

The Commission has now asked for such deficiency appropriation to the amount of $700,000, and they will in all probability obtain this added sum. It has also instructed its staff to arrange with the Advisory Committee for a more comprehensive list of cases where expensive drugs can be prescribed. They stated to your Chairman that they did not wish in any way to interfere with or curtail medical treatment but that they had been given a budget to stay within, and that the Administration was opposed to raising taxes for medical care or any other purpose. They asked that the profession be requested to use every effort to help them stay within this budget. My impression was that they are sympathetic with our viewpoint but that they are somewhat appalled by the overall cost of the entire program.

I also called their attention to the fact that nursing home care does not properly come under the listing of medical expenses and that we as a profession should not be held responsible for that. Also that while drugs costs are excessive in some communities where the local Advisory Committee is not very active, we will be better able to reduce expenses or hold them to a minimum when we are again permitted to try and regulate our own affairs. They seemed to approve of this attitude and I believe they will cooperate as they understand the human angle of the problems involved.

Since this problem will come up again in the next two years, and since the present Administration is rather inexperienced and somewhat unacquainted with the needs, your Committee suggests the following resolution:

"*Whereas,* medical care has gone forward so rapidly in the last few years that methods of treatment now are quite different than of even five or ten years ago, and

Whereas, these improvements have been important in prolonging life and relieving suffering, and

Whereas, the newer remedies and diagnostic procedures which make these improvements have of necessity caused an increase in the cost of these remedies,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Society request the Governor and other proper officials to make every effort to furnish adequate funds for the necessary care of the Old Age Pensioners, the Dependent Children, the Blind and the Disability Assistance cases, so that these unfortunate people, who are actually wards of the state, be enabled to continue to receive the excellent grade of medical care which they have been receiving up to the present time, but which care may now be jeopardized by the limitations of funds due to the recent cut in appropriation for the budget of the I.P.A.C. for the coming biennium."

Respectfully submitted, E. P. COLEMAN, M.D., *Chairman,* EDWIN S. HAMILTON, M.D., JULIUS H. HESS, M.D., HARLAN ENGLISH, M.D., B. E. MONTGOMERY, M.D., THEODORE R. VAN DELLEN, M.D., CHARLES P. BLAIR, M.D.

THE PRESIDENT: This will be referred to Committee "B".

ADVISORY COMMITTEE TO VETERANS ADMINISTRATION

The system of home town care of veterans, based on an agreement between the Illinois State Medical Society and the Veterans' Administration, continued to work satisfactorily throughout the year. No special problems have arisen and the committee therefore has held no meetings. Once more, too, while still cognizant of the profession's general attitude toward the system, it is a pleasure to report that our members concerned

have been cooperative, while the Chicago V. A. regional office staff, under C. H. Ogden, M.D., have discharged their duties considerately and satisfactorily.

Again, in 1952, the work load showed a definite decrease, as the following figures indicate:

VETERANS EXAMINED OR TREATED

	1950	1951	1952
By Fee Physicians	13,330	12,648	10,374
In V. A. Offices	87,724	72,217	53,657
Paid to Fee Physicians ..	$177,267	$128,662	$114,788
Paid to General Hospitals ..		$ 9,673	$ 13,311

Patients treated included 1,877 Spanish war veterans by fee physicians and 2,396 by V. A. staff.

One new aspect of the home town care arrangement should be called to the attention of the Society.

For more than a year the Veterans' Administration has been engaged in making contracts throughout the state with various nursing organizations to provide nursing care at home for veterans. These contracts are comparable to those now in existence with physicians, pharmacists and hospitals.

"It is believed," Dr. Ogden writes, "that where indicated, this service will be a distinct aid to the participating physician. Requests for it should be initiated by the physician at the time of his request for continuing treatment of the veteran."

The nursing organizations now under contract with the V. A. and the areas they serve are as follows:

NAME	AREA SERVED
Public Health Assn. of Aurora	Aurora Township
The Visiting Nurse Assn. of Chicago	Chicago
Macon County Tuberculosis and Visiting Nurse Assn.	Decatur and Macon County
Evanston Visiting Nurse Assn.	City of Evanston
Galesburg Visiting Nurse Assn.	Galesburg and East Galesburg
Public Health Council	City of and Township of Joliet and Village of Rockdale, Illinois
Civic Nurse Board	Kewanee, Illinois
Moline Visiting Nurse Assn.	City of Moline and area south of city limits to Rock River
Community Nursing Service of Oak Park and River Forest	Oak Park and River Forest
Associated Charities of Alton-Wood River District, Inc.	Alton, Wood River and Godfrey Townships of Madison County
Visiting Nurse Assn. of Peoria	Peoria, East Peoria, West Peoria, Peoria Heights, El Vista, Bartonville, Creve Coeur, Highway Village
Quincy Visiting Nurses Service	City of Quincy and 2 miles from city limits
Rock Island Visiting Nurse Assn.	City of Rock Island
Visiting Nurses Assn. of Rockford	City of Rockford and an area of 5 miles outside the limits in all directions
Visiting Nurse Assn. of Sangamon County	City of Springfield, including surrounding areas as far out as houses are numbered
North Shore Visiting Nurse Assn.	Glencoe, Kenilworth, Winnetka

Dr. Ogden concludes his report with the following statement:

"I desire to express the appreciation of the Veterans Administration for the excellent cooperation the participating physicians have given in submitting their requests for continuing treatment ten days prior to the expiration of the previous authorization.

"I particularly wish to express our appreciation for the careful analyzing and holding to a minimum their requests for continuing treatment during the past nine months when our medical program suffered a severe curtailment in allocated funds.

"We of the Veterans Administration feel that our program in the State of Illinois is one of the most outstanding and satisfactory in effect and it is through the cooperation of your Society and its officers that this has been made possible."

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* F. LEE STONE, M.D., *Vice Chairman,* LEO P. A. SWEENEY, M. D., CARL F. STEINHOFF, M.D., HAROLD M. CAMP, M.D., *Advisory Committee to the Veterans Administration.*

ADVISORY COMMITTEE TO THE UNITED MINE WORKERS

The Medical, Health and Hospital Care Program of the United Mine Workers of America Welfare and Retirement Fund has now completed its second year of uninterrupted operation; but the fourth year since it has been instituted, this being the Fourth Annual Report of this committee. The program, including medical care, hospitalization and rehabilitation, has progressed on a very stable basis during the past twelve months. Your committee has met with Dr. Sharp, the Area Medical Administrator and his co-workers, and our relationship with this group has been very satisfactory. We find them very cooperative and quite understanding of the medical problems involved. The committee met at the time of the last State Medical Society Meeting in Chicago, has held three other meetings during the year and will meet again at the time of the Annual Convention in May, 1953.

The services presently being made available to United Mine Workers of America miners and their dependents in Illinois through the St. Louis Area Medical Office are: (1) Medical care; (2) Hospitalization; (3) Rehabilitation. The following is a brief report on each of these three phases of health service:

1. Medical Care. The area medical office has made arrangements for practically all regularly licensed physicians practicing in the coal mining areas for the provision of necessary hospitalized medical or surgical care. A list of these participating physicians has been

printed and distributed to the participating physicians, hospitals and local union officers. The Fund does not provide for any routine home or office calls. Patients requiring routine home or office care secure this service from their family physician and pay him for this service as they have in the past. If the patient's illness is acute and requires hospitalization, the family physician may send the patient to the local hospital participating in the Fund's program. Arrangements have been made with practically all hospitals in the coal mining areas for their services. The family physician will have the patient admitted to a ward bed. If no ward beds are available, he will use semi-private room. If the patient is critically ill and requires the use of a private room for a few days, the attending physician may have the patient admitted to the private room during the critical phase of his hospitalization. Patients demanding a private room for their own convenience are required to pay the difference in cost between semi-private and private rates. If the family physician wishes to send the patient to an American Board Certified Specialist for a diagnostic service or consultation, he may either refer the patient directly to one of the specialists with whom the Fund has made arrangements or he may contact the St. Louis Area Office for their assistance in making arrangements for a special consultation. The costs of the diagnostic procedures and services provided by the specialist are paid for by the Fund. Both the family doctors and the patients seem pleased with the Fund's plan to make these specialists' services so readily available. Difficult diagnostic problems and surgical cases requiring highly trained specialists can be referred by the family physician at will, simply by writing a letter or making a phone call.

During the latter part of 1951 and up until May, 1952, the Fund was attempting to provide medically indicated tonsillectomies and dental care where the patient's dental condition was interfering with his recovery from a major medical problem. On May 15th, 1952, the Fund discontinued authorizing services for T. & A.'s and for dental care.

2. Hospitalization. The Fund has made arrangements with practically all hospitals located in the coal mining areas and in addition has made arrangements with some of the large hospitals in the university medical centers at the edge of the coal mining area. A list of these hospitals has been printed and distributed. Each eligible United Mine Workers of America miner has an identification card which he must present to the admitting clerk when sent to the hospital by any of the physicians on the staff of the participating hospital. This identifying card also lists the names of his wife and other eligible dependents. The Fund pays the hospital for the provision of all necessary hospital services for the duration of the period of necessary hospitalization. This includes drugs, laboratory, x-ray, operating room, anesthesia, etc. It does not include luxury items and incidentals as radio rental, telephone, cigarettes, newspapers, barber services, etc. The Fund does not purchase blood. Patients requiring transfusions should secure the necessary donors to replace the blood taken either from the blood bank or from the Red Cross.

3. Rehabilitation. The area medical office is attempting to rehabilitate as many as possible of the unemployed miners who have been disabled either because of an old injury or illness. (Industrial injuries are the responsibility of the coal company.) The first step in the rehabilitation of the disabled person is to secure from his physician a report on his previous injury or illness and his recommendations for further care. In most instances, the patient's disability has become quite chronic, difficult to handle, and usually requires the services of specialists in a large medical center. Following the actual physical restoration it is frequently necessary to send the patient to a rehabilitation center for physical therapy under the guidance of a psychiatrist. As soon as possible the patient is referred to the State Division of Vocational Rehabilitation for job training and placement.

Since January 1, 1951 the St. Louis Area Medical Office has had some 2,300 coal miners examined who have been disabled and unemployed for more than six months. 556 of these men have had sufficient physical restoration to warrant their referral to the Division of Vocational Rehabilitation in their state of residence. The referrals of 217 of these cases are still pending. 173 have been accepted for vocational training and placement, and 166 have been rejected as not vocationally feasible. Of the 173 accepted for vocational training, 87 have completed their training and 78 of these 87 are now in positions paying $40.00 or more per week. These men are now earning over $160,000.00 per year. Many of them were formerly receiving either public or private assistance.

The United Mine Workers Welfare and Retirement Fund is working closely with the physicians and hospitals in their efforts to improve the quality of medical services available to the coal miners. The liaison committee is now studying the problem of securing earlier referrals to the appropriate specialist for the adequate care of seriously injured miners in those cases where a physician on retainer by the coal company is responsible for providing the necessary medical care.

As in our report of last year, problems continue to arise throughout the mining area in reference to the Welfare Program. Occasionally misunderstandings occur on the part of the physician as well as on the part of the patient. The patient is frequently advised by his union officials that the Fund has more latitude and offers more than it actually is able to do. This requires a constant process of education on the part of the Medical Area Administrator and his associates as the personnel in the union changes, so that the membership can be correctly and properly advised. The doctors rendering the service also have some mis-

understandings from time to time and this is quite understandable when it is realized that in many communities as many as five or six different insurance programs are in effect, the United Mine Workers Program being only one of several. As they all vary in the services rendered and in the amounts allowed for various services, a certain amount of confusion and misunderstanding is quite to be expected. There has been some complaint from time to time in reference to the fees allowed, the Veteran's fee bill being the one which was followed. Yet since it has been in effect in the Veteran's Bureau for a number of years without change, it is a rather outdated schedule at this time. Complaints have come to this committee on several occasions based on the fact that the sum paid by the mine operators to the Welfare Fund has been doubled while the fees for physician's services have remained the same. If the industry remains stable for a long enough period of time with fairly steady employment, the fund will accumulate enough money so that probably changes in the fee bill can be made, although this will have to depend upon the stability of employment of the mine workers. Your committee feels that progress is being made steadily and a better understanding is being arrived at with those who administer the fund; that with patience and forebearance on the part of each side, conditions will slowly improve, that a higher grade of medical care will be furnished to the Mine Workers members, and that the physicians in this area will become increasingly more satisfied with the program as it develops.

Respectfully submitted, EVERETT P. COLEMAN, M. D., *Chairman,* W. W. FULLERTON, M. D., J. W. TIDWELL, M. D., B. E. MONTGOMERY, M. D., W. A. MONAGHAN, M. D., CHARLES AHLM, M. D., WILLIAM D. MOHLENBROCK, M. D., *Advisory Committee to United Mine Workers.*

ADVISORY COMMITTEE ON MILITARY AFFAIRS

The Illinois Advisory Committee to Selective Service and the Department of Defense, and the Military Affairs Committee of the Illinois State Medical Society, have worked together as one group in determining the essentiality or availability of physicians in this state.

We have processed cases of physicians in priorities I, II and III. When the physical standards were lowered 1 January 1953, for physicians accepting commissions, it was necessary for us to reopen many cases of priority I and II individuals who had previously been physically disqualified, to determine whether or not they could now be declared essential or available.

In reviewing these cases, we have requested the individual concerned to fill out a questionnaire for us, which gives us the necessary data with regard to his medical education, specialty, training and marital status — also teaching, research or hospital affiliation and whether or not he has had service with any branch of the Armed Forces, ally or co-belligerant of the United States during World War II. In addition to this questionnaire, we require the individual to send a letter indicating whether or not he desires deferment on an essentiality basis as the Advisory Committee will not consider requesting deferment on any case without such indication from the registrant or Reservist concerned.

The few men left in priorities I and II, who are still essential, should be available for service by 1 June 1953. Any exception to this must be reported to the National Advisory Committee with full justification being given for the extension of the deferment beyond 1 June 1953. This applies to priorities I and II only.

The Advisory Committee has processed the majority of the cases of priority III individuals born after 1910. We send them the same questionnaire and request the same type letter as on priorities I and II. Priority III physicians are eligible for call so their cases must be processed in the shortest time possible.

Letters have been sent to all teaching hospitals in Chicago and Cook County indicating the status of individuals on their staffs. This was done so men liable for service would not be appointed on their resident, teaching or research staffs and their staffs would not then be lowered beneath the minimum requirements to maintain the national health, safety or interest.

A schedule will be set up in the near future where a representative of the Advisory Committee will talk with the graduating students of medical schools in order that they may fully understand their liability for service under Special Registration.

The recommendations of this Committee were sent to the National Advisory Committee with regard to the new draft law concerning physicians, dentists and veterinarians. It was interesting to note that many of our suggestions were likewise suggested by other Advisory Committees and Government Agencies.

We believe we have maintained the highest type public relations with our physicans in this state and that has been our chief goal.

Respectfully submitted, CARL F. STEINHOFF, M. D., *Chairman,* HARRY M. HEDGE, M. D., JAMES MAJARAKIS, M. D., F. GARM NORBURY, M. D., HAROLD M. CAMP, M. D., *Advisory Committee on Military Affairs.*

COMMITTEE ON BLOOD BANKS

The action of the Committee during 1952 and 1953 was guided by the recommendations made by the previous committee action and published in the July, 1952 issue of the Illinois Medical Journal.

1. *A plan of operation with civilian defense authorities to better utilize blood banking facilities in case of an emergency.* The committee agreed that some definitive program be established with civilian defense authorities even though the possibilities of an immediate emergency do not appear imminent. It was also agreed that some system whereby all blood banks in the State of Illinois could be catalogued as to their capacities and the number of technical personnel available with re-

gional and alternate regional blood centers being accommodated. The Committee recommended the following to the Executive Council of the Illinois State Medical Society: The Illinois State Medical Society requests the Illinois Association of Blood Banks to establish a coordinated system of state-wide cooperation between hospital, community and Red Cross blood banks. The Association of Blood Banks will furnish the Blood Bank Committee of the Illinois State Medical Society with a list of the names of responsible individuals concerned with the program. The Illinois Association of Blood Banks is to set up state-wide regional and alternate regional centers of from 8 to 11 in number.

2. *Discussion of the value of a series of lectures to County Medical Societies to outline the properties of stored blood and* indicate the dangers of blood transfusions. The Committee agreed that an education program should be developed to bring to the attention of the physicians of Illinois the use and misuse of blood transfusions. The Committee recommended action by the Executive Committee of the State Medical Society. The recommendation was that the secretary of the Committee on Medical Education request acceptable dates from each County Medical Society for a lecture on blood transfusions. The speakers to be provided for this program would be obtained from a list supplied to the Secretary by the Illinois Association of Blood Banks. It was further recommended that the Illinois State Medical Society Journal publish a series of articles to emphasize the problems of blood transfusions.

3. *The desirability of a program sponsored by the Illinois State Medical Society under the jurisdiction of the State Department of Public Health to inspect and license private and hospital laboratories in crossmatching as well as in blood grouping and typing.* The discussion of this problem emphasized the need for all blood banks to adopt the minimum standards as established by the National Institutes of Health. The Committee agreed that blood banks should be inspected by the State Health Department only if the blood bank volunteers to be inspected. Since the Illinois Public Health Department was already certifying laboratories to accurately group and type blood it was thought advisable to have the Health Department include in their program a voluntary checking system whereby laboratories could be certified in crossmatching. The Committee recommends that the Illinois State Medical Society request the Department of Public Health to certify blood bank laboratories to adequately perform a crossmatch. The Committee further recommends that the Illinois State Medical Society request the Illinois Association of Blood Banks to officially adopt as a standard for blood banking the Minimum Standards of the National Institutes of Health. It was hoped that this might pave the way for the establishment of a state-wide interchange blood program.

Respectfully submitted, COYE C. MASON, M. D., *Chairman,* BENJAMIN MARKOWITZ, M. D., PAUL A. VAN PERNIS, M. D., WELLAND HAUSE, M. D., SIDNEY LEVINSON, M. D., G. GREENING, M. D., CHARLES PUESTOW, M. D., *Committee on Blood Banks.*

COMMITTEE ON CANCER CONTROL

During the past year or two encouraging experiments have been reported which give us hope that a cure for at least some malignant tumors may not be many years distant. Work being done at Memorial Hospital, New York and other Research Centers reveals chemicals which produce regression of animal cancers. Perhaps of more importance is the discovery attributed to E. J. Dornfeld, of Oregon State College that certain compounds, the nucleotides, restrain cell division. It would appear that chemicals with action of this type would seem to have the best prospect for success in the treatment of malignant disease.

Dr. John Rogers is Director of the American Cancer Society, Illinois Division. Concerning activities of the Illinois Division, Dr. Rogers reports as follows:

"Research continues to be a major activity of the Society. Twenty-five per cent of all funds collected are automatically allocated for this purpose. The Division sends 40 per cent of the gross collections to the national headquarters. Because Chicago is one of the great centers of cancer studies, the American Cancer Society last year made grants totaling $359,259 to Illinois investigators and institutions for cancer research projects. Altogether, the American Cancer Society and its Illinois Division distributed $391,859 to research projects within the state. The University of Chicago received an institutional grant of $150,000 and fifteen investigators at that institution received an additional $138,000. Four investigators at Northwestern University received $9,700, two investigators at Loyola received $7,750, thirteen investigators at the University of Illinois received $62,025, one investigator at Southern Illinois University received $4,000, one investigator at Illinois Institute of Technology received $2,500, three investigators at Michael Reese Hospital received $14,900, one investigator at DePaul received $1,000, and one investigator of the National Society for Medical Research received $1,000.

"The Illinois Division has received two legacies in the amount of $25,400, earmarked for cancer research in Illinois, thus permiting for the first time direct participation in the research program. In addition to these grants, clinical fellowships were made to six young physicians. The Division provided financial assistance to ten cancer clinics and six diagnostic clinics in the amount of $37,668. In addition, $8,731 has been given to cancer detection centers, all located in Chicago. This is considerably less than spent in previous years and the Division has adopted a policy to discontinue support of this type of activity. The

Division allocated $3,600 to the Home Care Plan at Michael Reese Hospital. This plan provides adequate treatment for patients in their homes, thereby relieving the shortage of hospital beds and at a daily cost of a little over $1.00 a day as contrasted with $15 per day for hospital care. Twenty-two visiting nurse associations in Illinois received a total grant of $18,505. Down-state chapters providing this service reported a total of 9,848 calls on 477 patients. These grants were provided on a cost-per-visit basis.

"The House of Delegates of the Illinois State Medical Society in May, 1952 approved the plan of the Committee on Cancer Control for a program based on an examination covering seven points for physicians in their own offices. This program, while not finished during the year 1952, is now complete and physicians throughout Illinois are being circularized to participate in what is aptly described by the slogan 'Every Doctor's Office a Cancer Detection Center.'

"The twelfth and thirteenth cancer refresher courses for physicians which last five days were sponsored by the Division in cooperation with the State Medical Society and the Chicago Medical Society. While attendance fell off somewhat, those physicians attending continued to attest its popularity. Two professional publications, 'CA-A Bulletin of Cancer Progress' and 'The Cancer Bulletin' were mailed on alternate months to 3,400 Illinois physicians. They are both available free to any Illinois physician desiring them. The Division has a library of six professional films on cancer, all relating to early diagnosis. These films were shown at 66 hospital staff meetings, 9 medical society meetings and to students in 11 medical schools. The film 'What Is Cancer?' which is for nurses only, was shown 74 times. A grant of $1,000 has been extended the Chicago Council on Community Nursing to assist in their schools for practical nurse training at Manley and Princeton Schools in Chicago. During the past year, 270 women have received this valuable training.

"The primary mission of the Illinois Division is the desire to assist physicians in every ethical way in the control of cancer within the state. Under the guidance and leadership of hundreds of physicians the public education program literally reaches hundreds of thousands of people. In addition to the thousands of pamphlets showing the seven danger signals of cancer distributed during the campaign, 860,000 additional pieces of educational literature were distributed during our year-round program. Our films were shown 2,936 times. Cancer educational programs were conducted in 512 high schools; 792 industries utilized posters, literature and films for their employees; 250,000 people visited our exhibit at the Museum of Science and Industry. Of particular interest is our film, 'Breast Self-Examination,' which points up the importance to women of making a habit of regular, methodical examinations of their own breasts. A total of 400,000 women in Illinois have seen the film so far.

"The Division operates 21 cancer information centers throughout the state. These centers, under the jurisdiction of county chapters of the Society, provide a vital link between the education and service programs. They provide counseling service to individuals seeking help for a personal or family cancer problem. Their reports show 43,000 individuals or families have contacted the centers for help during the year. These centers are directly supervised by the medical members of county chapter executive committees.

"Volunteers of the Society made and distributed 406,379 dressings to 1,269 patients in 65 counties. These dressings are free to any cancer patient upon request. There are now 26 loan closets throughout the state which provide for the loan of sick room equipment such as hospital beds, tables, wheel chairs, hospital jackets and bed linen."

Dr. G. Howard Gowen is Director of the Bureau of Cancer Control of the State Department of Public Health. He reports that there are now 28 cancer clinics in down state Illinois. Their activities may be summarized as follows:

New patients examined	4,300
Proved malignancies	1,580
Tissues examined from medically indigent patients	3,110
Number of clinic sessions	1,082
Physician visits to clinics	6,008

"In cooperation with the American College of Surgeons an outline of procedures was set up for the cancer program in general hospitals. This includes cancer clinics and also hospital-wide cancer registries. It is our aim, as soon as possible, to promote the establishment of hospital-wide cancer registries in all hospitals having cancer clinics. Once this has been done the program can be extended to include hospitals without cancer clinics. This is a long term project and is intended to fit in with the plan of the American College of Surgeons which will be instituted in approximately two years whereby a cancer clinic will not be approved unless the hospital has a hospital-wide cancer registry.

"The distribution of steroid hormones for use for medically indigent cases of far advanced cancer of the breast was discontinued. This program was originally set up on an educational basis to disseminate information about the use of such substances and to stimulate the interest of physicians in their use where indicated. Since the subject is now more or less general knowledge it was felt that our continuance of such a program could not be justified, particularly in view of the fact that we were supplying an agent for palliative treatment which is not basically the purpose of our program."

Respectfully submitted, WARREN H. COLE, M. D., *Chairman,* THOMAS C. GALLOWAY, M. D., EDWIN F. HIRSCH, M. D., RUSSELL M. JENSEN, M. D., JOSEPH S. LUNDHOLM, M. D., J. B. MOORE, M. D., J. J. MOORE, M. D., *Committee on Cancer Control.*

COMMITTEE ON CONSTITUTION AND BY-LAWS

The following changes in the Constitution and By-Laws are recommended by the Committee:

"Article VI. The Council.

Section 1. By deleting the parenthesis on line 9 around the words (the retiring president), and substituting a common therefor:

. and one councilor-at-large, the retiring president,.

Section 6. Delete "in the year 1940 and" and the word "thereafter" from lines 1 and 2. The Section will then read:

"Each year the Council shall appropriate from the funds of this Society."

By- Laws———

Chapter V. The House of Delegates.

Section 2. Special meetings. by adding the following:

"When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called"

This is offered to conform with the definition of a special session as contained in the By-Laws of the American Medical Association.

Amend by adding a new Section to be designated as:

Section 4. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified by his county society and so certified to the secretary of the Illinois State Medical Society.

When a delegate and his alternate are unable to attend a specified meeting, the appropriate authorities of the component society concerned may appoint a substitute delegate and a substitute alternate, who on presenting proper credentials, shall be eligible to regular membership in the House of Delegates.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that meeting. If a delegate, once seated, is unable to be present on account of sickness or for any other emergency, his place may be taken by an alternate, if approved by the Reference Committee on Credentials. After the alternate has been seated, he cannot be replaced.

Amend by changing Sections 4, 5, 6, 7 and 8 respectively to Sections 5, 6, 7, 8 and 9.

These changes are suggested to conform with the By-Laws of the American Medical Association, and because the present procedure has been followed without definition in the By-Laws."

Respectfully submitted, WARREN W. FUREY, M. D., *Chairman,* PLINY R. BLODGETT, M. D., A. F. GOODYEAR, M. D., JACOB E. REISCH, M. D., *Committee on Constitution and By-Laws.*

DR. WARREN W. FUREY: These amendments to the constitution and by-laws must be introduced at this meeting before they can be acted on by the Reference Committee. I shall, therefore, read the proposed amendments as they appear on Pages 122 and 123 of the Handbook. There is no supplementary report.

COMMITTEE ON CRIPPLED CHILDREN'S CLINICS

Crippled Children's Clinics in Illinois are well organized and cover almost every sizeable community in the entire state. The principal children's clinics are listed as follows:

Those held throughout the State.

1. The Illinois Elks Crippled Children's Committee.
2. Division of Services for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes.
3. A number of independent Crippled Children's Clinics are sponsored by individual County Medical Societies.

THE ELKS ASSOCIATION

Clinics held in 1952

*Total examinations 3,012

*Total number of cases hospitalized 165

*Number of days of hospitalization 6,380

Crippled Children's Clinics held in the Chicago area.

NORTHWESTERN MEDICAL SCHOOL; Montgomery-Ward Clinic.

Clinics held weekly—3

Estimated number of crippled children seen per week 4-5

THE UNIVERSITY OF CHICAGO

Clinics held weekly—6

Estimated number of children under 18 years of age 12-20

MOUNT SINAI HOSPITAL

Clinics held weekly—2

Most patients adults. Average of one crippled child per week

ST. LUKE'S HOSPITAL

Clinics held weekly—3

Approximate number crippled children seen per week—30

SHRINERS HOSPITALS FOR CRIPPLED CHILDREN

Clinics held weekly—2

Children seen weekly—70-100

*Figures incomplete on account of incomplete records. Quite a number of cases which are included in these statistics are adults.

Central Free Dispensary of West Chicago
One clinic per month
Average number of children seen per month—15

Cook County Hospital; Social Service Department
Orthopaedic clinics per week—7
Average number of children seen weekly—60-70

Michael Reese Hospital
Clinics held weekly—3
Approximate number of children seen per week—30

University of Illinois
Clinics held twice daily Monday through Friday
Approximate number of crippled children seen per week—105

The Children's Memorial Hospital
Clinics held weekly—2
Children treated in these clinics during 1952—387

Division of Services for Crippled Children, University of Illinois.

Towns	*Number Clinics*	*Av. Attd.*	*Towns*	*Number Clinics*	*Av. Attd.*
Peoria	24	1,584	Flora	2	152
East St. Louis	16	1,052	Fairfield	2	123
Springfield*	12	738	Evanston	2	62
Hinsdale	12	601	Carrollton	2	88
Rockford	12	597	Tuscola	2	100
Normal—			Clinton	2	110
Bloomington*	12	471	Centralia	2	86
Alton	8	478	Casey	2	93
Chicago Heights	6	265	Duquoin	1	101
Sterling	4	234	Jacksonville	2	69
Joliet	6	188	Chester	2	45
Danville	4	221	Monticello	1	67
Mt. Vernon	4	251	Effingham	1	69
Litchfield	3	184	Vandalia	2	73
Quincy	3	210	Pittsfield	2	60
Cairo	4	183	Anna	1	40
Elgin*	6	197	Shawneetown	1	62
Evergreen Park	5	199	Metropolis	2	50
Macomb	3	182	Watseka	2	136
Aurora*	6	187	Shelbyville	1	43
Salem	2	136	Rosiclare		

*Half-day Clinics.

Observation. In the majority of Crippled Children's Clinic Institutions authoritative data was given promptly in response to our questionnaire. The number of those who did not respond is smaller than that of last year.

Crippled Children's Clinics of Chicago. The majority of these are held in Institutions which have Medical School connections; they are usually staffed by Orthopaedic Surgeons who have Hospital Staff appointments. This arrangement facilitates and augments the proper care of the crippled child from the time he is first seen in the clinic through his admission to the hospital, his operative period and his postoperative care.

Downstate clinics are held in most of the counties and in all sizeable communities. The accessibility of these clinics is such that all crippled children can be brought to them regularly. Most of them are held periodically, several times a year.

Two new members have been appointed to the Illinois Crippled Children's Clinic Committee. They are:

Dr. Hugh Cooper, Peoria.

Dr. John J. Fahey, Chicago.

A meeting was held by this newly appointed Committee on the occasion of the Meeting of the American Academy of Orthopaedic Surgeons January 27, 1953. A complaint from the Effingham County Medical Society was investigated and discussed from all angles. Answers to all complaints and our conclusions were forwarded to Dr. Harold M. Camp, Secretary-Treasurer, Illinois State Medical Society.

Respectfully submitted, FRANK G. MURPHY, M.D., *Chairman,* HERBERT R. KOBES, M.D., GERARD N. KROST, M.D., HUGH COOPER, M.D., JOHN J. FAHEY, M.D., *Crippled Children's Clinic Committee.*

THE EDUCATIONAL COMMITTEE

The Educational Committee presents this report as a summary of its activities during the year. Two meetings were held, one via a telephone conference, November 9, 1952, and one in the Chicago Office, March 5. Another session is planned during the Annual Meeting of the Illinois State Medical Society.

TELEVISION:

After three and one-half years of regular programming, the Educational Committee left WGN-TV May 26, 1952 and returned November 26, 1952. Since the only real criticism directed at the telecast was the name "Health Talk," the Committee held a telephone conference November 9, 1952 to select a new name from a list of many. "How's Your Health" was chosen.

Random comments received in the mail include the following:

"I hope you will bring your health program back on TV. We need more educational material like yours on TV."

"We have found your TV programs very interesting and look forward to watching them again when you return to the air."

"Your TV show was enjoyed all winter and a revelation to all viewers I am sure. May your blessed work continue."

"Your program "How's Your Health" is a great contribution to the television field. An adult, interesting and instructive or rather enlightening program is appreciated by all. Thank you."

"Enjoy your TV show very much and would like to see some more surgery in the future."

Since the last annual report twenty-seven programs have been televised by the Committee involving thirty-two physicians, one dentist and one Ph. D. In addition appearing in the various telecasts were five interns,

eight nurses, one medical student, two technicians, one airplane pilot and twenty-three patients. Dr. Theodore R. Van Dellen, Medical Editor of the Chicago Tribune, appeared on all telecasts as moderator. The Chairman of the Educational Committee wrote personal thank you letters to every participant in each telecast and to all hospitals and cooperating companies.

The Committee wishes to acknowledge its appreciation to the following who cooperated with "How's Your Health" by providing equipment and lending valuable assistance: Chicago Lying-In Hospital, Shriners Hospital for Crippled Children, Illinois Masonic Hospital, Wesley Memorial Hospital, Loretto Hospital, Ohio Chemical and Surgical Equipment Company, V. Mueller and Company, Abbott Laboratories, Clay-Adams Company Inc., Cambridge Instrument Company, Bausch and Lomb Optical Company, Uhlemann Optical Company, Mager and Gougelman, United Airlines, Denoyer and Geppert Company, and Standard X-Ray Company.

The television program "All About Baby" was presented on WNBQ during the past year by the Herbert Laufman Advertising Agency. The Educational Committee scheduled all physicians appearing on this weekly program, a total of forty-nine. Since all participants on the telecast were paid, the physicians also received compensation in keeping with the policy of the Educational Committee. On April 8 the series is to be moved to ABC on Channel 7 under the same arrangement, although credit will now include the Educational Committee of the Illinois State Medical Society.

Five persons were scheduled to appear on "They Stand Accused," a WGN-TV network production which is now off the air.

In addition assistance was given to NBC in developing a telecast on "The Family Doctor;" one physician appeared on the telecast and credit line was included to the Educational Committee.

In October the showing of a kinescope of one of the Committee's regular telecasts, "Brittle Bones," was a feature of the TV session of the American Public Health Association which was sponsored by the American Medical Association. "How's Your Health" was also highlighted at the public relations session of the American Medical Association at the Edgewater Beach Hotel in September.

In the past year requests for information concerning "How's Your Health" have come from the Harris County (Texas) Medical Society; Allegheny County (Pennsylvania) Medical Society; Cleveland Health Museum, California Medical Association, Medical Society of Milwaukee County (Wisconsin); Colorado State Department of Public Health, Greater Boston Academy, Boston, Massachusetts.

RADIO:

The radio series "Your Doctor Speaks" is now in its fourth year over FM Station WFJL. In the past year fifty-two physicians have prepared manuscripts for presentation at the request of the Committee. All manuscripts have been reviewed carefully by each member of the Committee and recommended changes were returned to the author to include in the manuscript.

One Champaign physician who appeared in the series was given permission to reproduce his radio talk in the bulletin of the Carle Hospital Clinic.

One physician was scheduled to appear in a special radio broadcast with Fahey Flynn over WBBM.

SPEAKERS' BUREAU:

One hundred and three speakers were scheduled before various organizations meeting throughout the state. These included chapters of the Women's American O. R. T., Women's Auxiliaries to medical societies, mothers' clubs, church groups, district chapters of the Illinois Federation of Women's Clubs, Kiwanis, Lions and Rotary Clubs, child study groups, Illinois Congress of Parents and Teachers, Salvation Army Catherine Booth Hospital and Clinics, Physicians Fellowship Club Auxiliary, Industrial Editors' Association, Bond Company Health Improvement Association, Catholic Daughters of America, National Catholic Kindergarten Association, and libraries, schools of nursing, Student AMA chapter, Stritch School of Medicine of Loyola University, Y. W. C. A., Y. M. C. A., schools, and the Illinois Welfare Association.

HEALTH TALK:

The weekly mailing list for Health Talk is 1,085 and the monthly list, which includes two issues in each mailing is 4,263. In February sixty-eight advisers of the Health Improvement Associations were removed from the monthly list and transferred to the list of specials to receive twenty copies each. In addition twenty-one individuals receive 2,108 copies each month for distribution through rural areas. This gives a total of eighty-nine individuals receiving 13,354 issues for general distribution. During June, July and August the schools are removed from the mailing list.

This past year the names of presidents and secretaries of county and branch medical societies were added to the weekly mailing list.

This past year the names of presidents and secretaries of county and branch medical societies were added to the weekly mailing list.

Several teachers requested a file of Health Talks since its inception. These persons, however, were told that this could not be done. Requests to be placed on the mailing list came from the public in general, teachers, nurses, physicians and students.

The mailing list for Health Talk is generally restricted to Illinois although there are a few exceptions. In the past year requests have come from Arizona, California, Connecticut, Georgia, Indiana, Kansas, Kentucky, Maryland, Michigan, New Mexico, New York, Ohio, Rhode Island, Tennessee, Virginia and Washington. All state medical societies are on the weekly list.

Blue Print for Health featured two issues of Health

Talk this past year, one on "Your Cough Is a Symptom" and "Inside the Operating Room." Science News Letters featured the issues of "Brittle Bones" and "Exercise." The National Catholic Kindergarten Review used two issues "Stuttering Can Be Overcome" and "School Health and Your Child."

During the year 101 persons requested a total of 8,453 issues of Health Talk in varying amounts. These came from schools, the University of Illinois College of Agriculture, nursing units, PTA health chairmen, radio stations, health departments, colleges, Y. M. C. A., Y. W. C. A., Industrial Editors Association and special groups. One PTA health chairman requested 600 copies of "Mental Health of Your Child," one teacher, 200 copies of "Immunization Against Disease" and twenty-six health chairmen requested 2500 issues on "School Health and Your Child." A total of 2,000 issues of varying subjects were given to one Y. M. C. A. for a special health meeting. In August Mrs. H. A. Bertram, Health Chairman of the Illinois Federation of Women's Clubs, requested twenty-five sets of three different issues of Health Talk to include in her packets to twenty-five district chairmen. In addition, 1,000 copies of one issue were given to her for distribution to about 1,000 clubs.

It is interesting that Ray Duncan, formerly of the Illinois Department of Education and now Dean at the University of West Virginia School of Physical Education and Athletics, wrote for two copies each of certain issues of Health Talk which were of widespread interest when he was in Illinois.

MISCELLANEOUS:

The Chicago staff assisted in the removal of the office to the location at 185 North Wabash Avenue.

The Committee functioned without stenographic assistance from August 15 to late January, when a former employee, Mrs. Patricia Schaadt, returned for a limited period on a part time basis. Gray Audiograph dictating and transcribing equipment was installed in the Chicago Office February 27.

In October the Secretary attended the American Public Health Association meeting in Cleveland to attend a TV Clinic sponsored by the American Medical Association. She gave a one hour lecture before the sophomore class of Stritch School of Medicine of Loyola University, March 7, and is to address the Woman's Auxiliary to the Champaign County Medical Society in Danville, April 7. The Secretary also served as Mailing Chairman for the Industrial Editors Association, was the program chairman for the day at one meeting and attended sessions of the Chicago Publicity Club and the Illinois Women's Press Association.

The Secretary has kept in regular touch with the Committee by letter, reporting all activities in some detail and resorting to the telephone when immediate decisions were required.

The Educational Committee staff performed the activities rendered by the Scientific Service and Medical Economics Committee, prepared the "News of the State" and obituaries in the Illinois Medical Journal, publicity in the Bulletin of the Chicago Medical Society, as well as press releases pertinent to activities of its own and that of the Scientific Service Committee.

Letters, programs, agenda and other material were mimeographed for the Women's Auxiliary to the Illinois State Medical Society for its annual meeting as well as for its board meetings, September 25, 1952, and March 12, 1953. The committee reports for the Auxiliary for the 1952 sessions were also mimeographed.

The Committee expresses its appreciation to the 232 physicians who cooperated in all its activities to disseminate sound health information either by television, radio or "live" talks before various groups. It acknowledges the cooperation of all personnel within the various offices of the Illinois State Medical Society and the Chicago Medical Society.

The Committee, in submitting this report, acknowledges with deep appreciation the confidence given to it by the Council and the House of Delegates of the Illinois State Medical Society.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman,* KARL L. VEHE, M.D., *Co-Chairman,* GEORGE V. BYFIELD, M.D., GEORGE L. DRENNAN, M.D., JOSEPH T. O'NEILL, M.D., MISS ANN FOX, *Secretary.*

ETHICAL RELATIONS COMMITTEE

Your Committee is pleased to report that there has been only one case referred to this Committee during the past year. This was an appeal in the case of a member expelled from the Chicago Medical Society.

Inasmuch as appeals to the State Medical Society consist of review of the question as to the regularity of procedures at the former trial to see that the rights and privileges of the defendant have been followed, your Committee were of the opinion that the inquiry and procedures were in correct order and therefore supported the action of the Chicago Medical Society.

Respectfully submitted, CHARLES H. PHIFER, M.D., *Chairman,* CHARLES ALLISON, M.D., V. E. ADAMS, M.D., *Committee on Ethical Relations.*

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health of the Illinois State Medical Society presents a summary of its activities for the past year as follows: It is difficult for all the members to attend the two meetings called during the year so that a full membership of the committee could not be held at any time. However, the problems confronting industrial health and industrial medicine were very much the same as in previous years.

The outstanding meeting which deals directly with industrial health was the thirteenth annual Congress on Industrial Health sponsored by the Council on Industrial Health of the American Medical Association

held at the Drake Hotel, Chicago on January 20-22, 1953. The committees on industrial health of the various state medical associations were in joint conference at the meeting as was the Chicago Medical Society. Your committee would urge very strongly that all members of the Illinois State Medical Society who are interested or actively engaged in industrial medicine and surgery attend the annual Congress on Industrial Health which is held annually.

The program at this meeting was a most outstanding one wherein every phase of industrial health was discussed by men of authority and those directly interested in this important phase of medicine—one of the highlights being a discussion on "How Can We Best Maintain the Health of the Nations Work Force," by a representative of management, labor and medicine. Your President-Elect of the A. M. A. representing medicine gave a most interesting and enlightening discourse. The Council on Industrial Health of the American Medical Association is to be most highly commended for its excellent administration of its duties.

The question of maintaining the health of the nation's industrial workers lies in the cooperation of management, labor and medicine since a healthy force and pleasant environment are essential to productivity and to the welfare of democracy.

So much can be done to educate the people by giving them an opportunity to learn the real facts concerning health—warn them against quacks and nostrums—correct any misinformation so often found in the press, TV and radio. This can be part of the program of the medical staff of industry and would foster more confidence and respect for the members of the medical profession. Much remains to be done relative to occupational diseases—studies of occupational cancer can be pursued by the medical staffs of the various industries in conjunction with state health departments and universities interested in this study—public health service and other groups. With cooperation of this nature a vast amount of knowledge could be obtained and much benefit obtained.

It is obvious that a large industry which has a medical force of several hundreds of doctors, technicians, nurses, dietitians, etc., can have a well-balanced program of every phase of industrial medium, but it is essential that a small plant should have equally as good medical service.

The primary aim must be the good of the employees—the resulting improvement in health condition tending to increase productivity and thereby increasing returns to management.

Pre-employment examinations, care of occupational illness or injury, the latter including rehabilitation, industrial hygiene, administration of sickness, insurance benefits, health counseling and many other duties are included in the function of the medical department.

There is still a threat of powerful labor unions and some industries taking over medical services to the detriment of medicine. Much can be done to avert this possibility by the members of the medical profession if they are alert to this danger.

It is gratifying to note the rapid increase in number of employees that are protected by and with group health and hospital insurance. It is also gratifying to note the better cooperation with the family physicians in industrial areas.

Respectfully submitted, DAVID B. FREEMAN, M.D., *Chairman,* JOSEPH H. CHIVERS, M.D., RICHARD J. BENNETT, JR., M.D., HAROLD A. VONACHEN, M.D., R. I. BARICKMAN, M.D., E. L. COMPERE, M.D., *Committee on Industrial Health.*

MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee has continued with its program of reviewing the maternal deaths in the state outside of Chicago as in the past. The data has been collected by Dr. Charles Newberger as each case occurred, and a protocol has been prepared and sent to each member of the committee. These protocols were reviewed and the committee determined whether or not, a) the death could be considered maternal or non-maternal, and b) whether it was preventable or non-preventable, or whether they were preventable factors involved on the basis of the report made by Dr. Newberger.

The almost unbelievable low figure of .4 per 1000 live births has been attained for the downstate area, and .3 for the Chicago area which puts us as a state well up with the leaders. When requested the committee has sent to the physician in charge of a maternity case which ended fatally, a review of their opinion based on a consideration of the data presented to the committee, and the doctor has been invited to attend the next meeting of the committee if he wishes to review his case with the committee.

Each member of the committee now has an alternate who serves for the committee member in case the latter cannot attend a regular meeting.

The committee has been active further with the Congress of the American Committee on Maternal Welfare held in Cincinnati in 1952. Various members attended in person and others assisted in obtaining permission for Obstetrical Supervisors to attend the meeting.

The committee members have been active in the development of the Illinois Obstetrical and Gynecological Society which now is a strong organization composed of over one hundred men who collectively are delivering or supervising in a broad way, the deliveries of a large percentage of the babies born in the state.

Most cordial relations have been maintained with the State Department of Public Health.

Through this cooperation of all of these organizations the maternity service offered to the citizens of our state is second to none in the United States.

Though much has been accomplished, the committee

can clearly see where further improvement can be made and is planning additional activities which will still further implement the objectives for which it was created by the parent society.

Respectfully submitted, F. H. FALLS, M.D., *Chairman, Committeemen:* A. B. OWEN, M.D., F. J. P. TWOHEY, M.D., W. R. YOUNG, M.D., R. R. LOAR, M.D., M. BITTER, M.D., J. B. WALLER, M.D., C. GREENSTEIN, M.D., C. E. AHLM, M.D., W. C. SCRIVNER, M.D., J. C. CAREY, M.D. *Alternates:* JOHN SMITH, M.D., R. N. REDMOND, M.D., F. J. STEWART, M.D., C. H. BALL, M.D., F. X. DEVER, M.D., V. M. LONG, M.D., R. C. BUCKER, M.D., J. W. TIDWELL, M.D., J. M. COLLINS, M.D., E. B. SYLVESTER, M.D., A. J. MAUZEY, M.D.

COMMITTEE ON MEDICAL ECONOMICS

Your committee has been active and diligent in its desire to provide a monthly article in the Illinois Medical Journal on the general subject of Medical Economics. Since the last report to the House of Delegates the following articles have appeared in the Illinois Medical Journal: "From Dusk to Dawn," April 1952; "Speak Up Doctor, Loud and Clear," May; "The Challenge," July; "Medicine and Conformity," August; "Which Pension or What Pension Relief," September; "The Physician and the Voluntary Health Agencies," October; "Blue Cross/Blue Shield," December; "Archives in the Catacombs," January 1953; "The V. A. Hospital and the Private Physician," February; "Please Doctor, Your Rhetoric," March; and "School Health in Illinois," April, 1953.

No Medical Economics articles were published in the June or November issues because of lack of space in the Journal due to the published proceedings of the 1952 annual meeting.

The committee held a dinner meeting at the Sherman Hotel, August 14, 1952. Plans for the ensuing year were formulated, specific commitments were made by the members, and general policies were discussed. The chairman also reported the activities of this committee to the Council at its November meeting.

The articles are written by individual committee members, or upon occasions by well qualified "guests" suggested by one of the members. The written article is then distributed to each committee member. Suggestions as to a catching title, choice of words and phrases, and criticisms of the subject matter are made and returned to the author. The author has the choice of stating his authorship or publishing under the committee heading.

Your committee does not seek to compete with other journals pertaining to medical economics, but rather to consider wider subjects of interest to the physicians of the entire state. We do not attempt to solve existing problems, but do hope to stir your thoughts toward action.

Timeliness is the essence of news, yet this is the major problem of any monthly publication. To avoid staleness and yet insure delivery, a small backlog of papers is required. Articles are mailed to the editor in the order received by the committee. Exceptions are made to insure timeliness when necessary.

The committee expresses its thanks and appreciation to the staff of the Chicago office of the Illinois State Medical Society for its technical and secretarial assistance in assisting this group in fulfilling its objectives.

Respectfully submitted, JOHN R. WOLFF, M.D., *Chairman,* WALTER C. BORNEMEIER, M.D., EDWARD W. CANNADY, M.D., ROLAND R. CROSS, M.D., W. R. MALONEY, M.D., CAESAR PORTES, M.D., WILLIAM REQUARTH, M.D., FREDERICK W. SLOBE, M.D., E. F. DIETRICH, M.D., W. W. FULLERTON, M.D., EDWIN F. HIRSCH, M.D., FREDERICK T. JUNG, M.D., *Committee on Medical Economics.*

COMMITTEE ON MEDICAL HISTORY

This is the Society's fourth venture into the writing of Medical History in Illinois. In the late 90's, Dr. W. O. Ensign of Rutland was asked to compile a history and to present it at the next annual meeting. The time limit imposed indicated how little the Society realized the difficulty of the task which was not completed. In 1913, Dr. Carl E. Black, on orders from the Council, brought out a history "Transactions of the Illinois State Medical Society from 1850 to 1898." This was a resume of what had transpired at the annual meetings during the period covered. Dr. Black said one purpose of it was to stimulate others to write more detailed accounts.

In 1927 Dr. Zeuch brought out a "History of Medical Practice in Illinois, Volume I." A committee was in charge of this but Dr. Zeuch was the editor and did most of the work. The volume appropriately bears his name. It was several years in preparation and covers the period up to 1850. It contains a vast amount of interesting and valuable material and shows something of the part played by individual physicians and medical societies in the development of the State. The doctors of that period were interested almost as much in religion and education as they were in medicine. They founded schools and colleges all over the State and helped to inaugurate the State's public school system. They founded some churches and contributed to others. Some of them acted as ministers. Others helped to build railroads and laid out towns and villages. Some were editors. They made records we may all be proud of.

They had almost none of the aids we have now for the diagnosis and treatment of disease. Most of those things have come to us since 1900.

Pickard and Bulley dedicate their book, "The Midwest Pioneer: His Ills, Cures and Doctors," "To the pioneer doctor who boldly faced the wilderness, and to the pioneer who bravely faced the doctor."

When the cost of medical care is discussed we should

remember that at one time cattle sold for about $7.50 per head in Indianapolis and quinine cost $6.00 to $8.00 per ounce.

This Committee was created nearly six years ago. It is hoped that its labors will be completed and Volume II in print before the House of Delegates meets in 1954. As was mentioned in last year's report, there are two ways a history of this kind may be written. One is to employ a historical writer and turn the job over to him. Usually such persons are not medically trained and may not select the medically important facts for inclusion in the book; or they may place too much emphasis on events physicians consider of secondary importance. The other method, which was followed by your Committee, is to ask men interested in various aspects of medicine to write the story of that which they are most familiar. For instance, Dr. Kellogg Speed has written the story of surgery, Dr. Frederick Falls that of obstetrics, and Dr. Helga M. Ruud has written the history of women in medicine—and a very interesting story it is. Dr. Camp is writing the story on medical societies and Mrs. Frances Zimmer has written the history of the annual sessions of the House of Delegates. Dr. Tom Kirkwood has written the history of Lawrence County and is writing a history of medical practice in that part of the State. By the way, the first instance of group practice in Illinois was in Saline County. Dr. E. B. Montgomery of Quincy—in practice 75 years—has written an interesting story of obstetrics in that part of the state.

Because the contributors are busy people it naturally takes more time to collect the material in this way.

However, between 80 per cent and 90 per cent of the material is complete and in the hands of the Committee. Dr. D. J. Davis has consented to act as editor and is already at work on that job. The book will be about the same size as Volume I.

Contributors understand that the editor may have to condense some manuscripts where two writers cover part of the same subject. But the manuscripts will be kept intact and deposited in the Crerar Library.

This Committee has laid the foundation for future volumes. Considerable data has been accumulated that did not belong in this volume. Instead of discarding it this has been deposited in the Crerar Library.

This has been a long, slow and interesting task which is now nearing completion. The Chairman is indebted to every member of the Committee, to the Council and to its Chairman and several individual Councilors for their cooperation and support. Mr. Leary has given valuable advice from the practicle angle of book making and publishing. It is hoped the book will be of interest not only to physicians but to many laymen as well.

Respectfully submitted, JAMES H. HUTTON, M.D., *Chairman,* JOSIAH J. MOORE, M.D., DAVID J. DAVIS, M.D., E. H. WELD, M.D., GEORGE COLEMAN, M.D., JAMES P. SIMONDS, M.D., CHARLES P. BLAIR, M.D., TOM KIRKWOOD, M.D., OTTO KAMPMEIER, M.D., WILLIAM A. MANN, M.D., FREDERICK W. MERRIFIELD, M.D., KELLOGG SPEED, M.D., ARCHIBALD HOYNE, M.D., R. BARKER BEESON, M.D., *Committee on Medical History.*

COMMITTEE ON MENTAL HEALTH

There have been no special questions referred to the Committee so far as known. The chairman has continued as a member of the Mental Health Advisory Committee for the State Department of Public Welfare. He is considered the representative of the Illinois State Medical Society on this committee although the appointment came from the Director of the Department of Public Welfare. Consequently his activities on that committee have been in the direction of endeavoring to correlate the use of Federal Funds for Mental Health Clinics in the State of Illinois along the lines of the principles and policies of organized medicine. Incidental contacts have been kept up with the Department and with the private institutions in Illinois. Comments relative to the interpretation of the revised Mental Health Code have been made to individual physicians and to some groups from time to time. It is felt that the excellent cooperation of the Department of Public Welfare with organized medicine which characterized the previous administration will continue.

Respectfully submitted, F. G. NORBURY, M.D., *Chairman,* ABRAHAM LEVINSON, M.D., OSCAR HAWKINSON, M.D., GERALD M. CLINE, M.D., C. C. ELLIS, M.D., *Committee on Mental Health.*

COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

Up to the present time, the specific planning in the Health Service field of the Civil Defense has been left to the local communities. Pertinent Guiding Manuals have been issued by the Federal Civil Defense Agency.

A critical survey of the seven target areas and the population centers in the State has been conducted by the Deputy Director for Health Services of the Civil Defense Agency of Illinois during the past six months.

A Statewide plan for the optimum utilization and allocation of First Aid Stations and Improvised Hospitals from the strategic and tactical viewpoints has been developed and released to local Civil Defense authorities throughout the State.

This plan was studied by this Committee and approved as sound and feasible. It seems to represent the basic minimum needs in the Aid Station and Improvised Hospital field. The number of Units thought basically necessary was below the number recommended by the FCDA, which recommends by reason of population in the Critical Target Areas, whereas the Illinois estimate is based on the estimated bomb drop. The conclusion was reached that in all probability a bomb drop of three bombs would represent conservative realistic planning.

Since approximately 96 Aid Stations, each capable

of treating 1000 casualties in 24 hours are required to render Aid Service around the perimeter of the average A Bomb, 3 x 96 = 288 Aid Stations would be required.

Three Improvised Hospitals in each of the four zones of the average A Bomb attack would seem to be the minimum requirement. This amounts to Twelve Improvised Hospitals around the perimeter of each bombed area, or thirty-six for the Three-bomb-drop potential.

The distribution of these Units seems to have been made in the widest geographical manner consistent with good "Critical target" area support. It is felt that this is desirable because we believe that the greater number of Communities actively participating in this program, the greater will be the impetus to the entire Civil Defense effort.

The cost of these units will be borne equally by the Community and the Federal Government on a matching basis.

The present cost of the recommended equipment for a First Aid Station is $3,416.00, while that for the recommended Improvised Hospital is $27,257.31.

Attached are the lists of Cities and the Units recommended for each, the Manning Tables, and the Tables of Equipment for both the Aid Stations and the Improvised Hospitals.

Respectfully submitted, EARL H. BLAIR, M.D., *Chairman,* F. T. BRENNER, JR., M.D., PLINY R. BLODGETT, M.D., KENNETH H. SCHNEPP, M.D., ROLAND R. CROSS, M.D., LEO P. A. SWEENEY, M.D., PHILIP LEWIN, M.D., GILBERT EDWARDS, M.D., *Committee on Military Affairs and Emergency Medical Service.*

The following list is the cities, their population, and the number of first-aid stations of the type capable of treating 1000 patients in 24 hours which should be organized in each community.

City	*Population*	*No. of First Aid Stations*
Chicago	3,620,000	101
Peoria	112,000	4
East St. Louis	82,000	3
Rockford	93,000	3
Aurora	51,000	2
Berwyn	51,000	2
Cicero	68,000	2
Decatur	66,000	2
Evanston	74,000	2
Joliet	52,000	2
Oak Park	64,000	2
Rock Island	49,000	2
Springfield	82,000	2
Alton	33,000	1
Anna	4,000	1
Arlington Heights	9,000	1
Barrington	4,000	1
Batavia	6,000	1
Beardstown	6,000	1
Belleville	33,000	1
Bellwood	9,000	1
Belvidere	10,000	1
Benton	8,000	1
Bloomington	34,000	1
Blue Island	18,000	1
Bradley	6,000	1
Broadview	5,000	1
Brookfield	16,000	1
Cairo	12,000	1
Calumet City	16,000	1
Canton	12,000	1
Carbondale	11,000	1
Carlinville	5,000	1
Carmi	6,000	1
Centralia	14,000	1
Champaign	40,000	1
Charleston	9,000	1
Chester	5,000	1
Clinton	6,000	1
Collinsville	12,000	1
Creve Coeur	6,000	1
Crystal Lake	5,000	1
Danville	38,000	1
DeKalb	12,000	1
Dixon	12,000	1
Dolton	6,000	1
Downers Grove	12,000	1
DuQuoin	7,000	1
East Alton	7,000	1
East Moline	14,000	1
East Peoria	9,000	1
Edwardsville	9,000	1
Effingham	7,000	1
Eldorado	5,000	1
Elgin	44,000	1
Elmwood Park	19,000	1
Evergreen Park	11,000	1
Fairfield	6,000	1
Flora	5,000	1
Forest Park	15,000	1
Franklin Park	9,000	1
Freeport	23,000	1
Galena	5,000	1
Galesburg	32,000	1
Geneseo	4,000	1
Geneva	5,000	1
Glencoe	7,000	1
Glen Ellyn	10,000	1
Glenview	6,000	1
Granite City	30,000	1
Greenville	4,000	1
Harrisburg	11,000	1
Havana	4,000	1
Herrin	10,000	1
Highland	4,000	1
Highland Park	17,000	1
Hillsboro	4,000	1

Hinsdale	9,000	1
Homewood	6,000	1
Hoopeston	6,000	1
Ingalls Park	7,000	1
Jacksonville	20,000	1
Jerseyville	6,000	1
Johnston City	4,000	1
LaGrange	14,000	1
LaGrange Park	6,000	1
Lake Forest	8,000	1
Lansing	9,000	1
LaSalle	12,000	1
Lawrenceville	6,000	1
Libertyville	6,000	1
Lincoln	14,000	1
Litchfield	7,000	1
Lockport	5,000	1
Lombard	10,000	1
Loves Park	5,000	1
Lyons	6,000	1
Macomb	11,000	1
Madison	8,000	1
Marion	11,000	1
Marseilles	5,000	1
Mattoon	18,000	1
Melrose Park	13,000	1
Mendota	5,000	1
Metropolis	6,000	1
Milton	8,000	1
Moline	37,000	1
Monmouth	11,000	1
Morris	7,000	1
Mt. Carmel	9,000	1
Mt. Prospect	4,000	1
Mt. Vernon	16,000	1
Murphysboro	9,000	1
Naperville	7,000	1
Normal	10,000	1
North Chicago	9,000	1
North Lake	4,000	1
Oaklawn	9,000	1
Olney	9,000	1
Ottawa	17,000	1
Palatine	4,000	1
Pana	6,000	1
Paris	10,000	1
Park Forest	8,000	1
Park Ridge	17,000	1
Pekin	22,000	1
Peoria Heights	6,000	1
Peru	9,000	1
Pontiac	9,000	1
Princeton	6,000	1
Quincy	42,000	1
Rantoul	6,000	1
Ridgewood	6,000	1
Riverdale	6,000	1
River Forest	11,000	1
River Grove	5,000	1
Riverside	9,000	1
Robbins	5,000	1
Robinson	6,000	1
Rochelle	6,000	1
Rock Falls	8,000	1
St. Charles	7,000	1
Salem	6,000	1
Savanna	5,000	1
Shelbyville	4,000	1
Skokie	15,000	1
Spring Valley	5,000	1
Staunton	4,000	1
Steger	4,000	1
Sterling	13,000	1
Streator	17,000	1
Summit	9,000	1
Sycamore	6,000	1
Taylorville	9,000	1
Urbana	23,000	1
Vandalia	6,000	1
Venice	6,000	1
Villa Park	9,000	1
Washington	4,000	1
Washington Park	6,000	1
Watseka	4,000	1
Waukegan	39,000	1
Westchester	4,000	1
Western Springs	6,000	1
West Frankfort	11,000	1
Wheaton	12,000	1
Wilmette	18,000	1
Winnetka	12,000	1
Wood River	10,000	1
Woodstock	7,000	1
Zion	9,000	1

The following list indicates the cities and the number of improvised hospitals which would be organized on the basis of the FCDA 200 bed improvised hospital.

City	*Population*	*No. of Improvised Hospitals*
Chicago	3,620,000	6
Alton	33,000	1
Aurora	51,000	1
Belleville	33,000	1
Berwyn	51,000	1
Bloomington	34,000	1
Champaign	40,000	1
Chicago Heights	25,000	1
Cicero	68,000	1
Danville	38,000	1
Decatur	66,000	1
Desplaines	15,000	1
East St. Louis	82,000	1
Elgin	44,000	1
Elmhurst	21,000	1
Evanston	74,000	1
Galesburg	32,000	1
Granite City	30,000	1
Harvey	21,000	1

Joliet	52,000	1
Kankakee	26,000	1
Kewanee	17,000	1
Maywood	28,000	1
Moline	37,000	1
Oak Park	64,000	1
Peoria	112,000	1
Quincy	42,000	1
Rockford	93,000	1
Rock Island	49,000	1
Springfield	82,000	1
Waukegan	39,000	1
Total		36

These listings provide 101 aid stations within the city limits of the City of Chicago, 89 aid stations in direct support of Chicago, leaving 98 aid stations for the remainder of the State. This will provide the City of Peoria with 20 aid stations for direct support, the Rock Island-Moline area with 12 aid stations for direct support, and the East St. Louis-Alton area with 27 aid stations for direct support.

In the improvised hospital field, this provides 15 improvised hospitals for the primary support of Chicago, and 15 for the remainder of the State.

The procurement of supplies and equipment for first-aid stations and improvised hospitals, contemplated in this plan, should be those listed in FCDA Manual 25-1 which is in the possession of all city and county Civil Defense Directors.

The following manning tables are recommended for use in the organization of the first aid stations:

MANNING TABLE OF A FIRST AID STATION
(Activation Status)*

Personal	*First Aid Station Group*	*Field First Aid Group*	*Ambulance Group*	*Litter Bearer Group*	*Total*
Physicians	2				2
Physicians' Assistants	2				2
Nurses	2				2
Nurses' Aides	4				4
Adm. Asst. or Pharmacist	1				1
First-Aid Technicians	10	10			20
Orderlies	9		6		15
Litter Bearers				64	64
Chaplain	1				1
Clerks	2				2
Decontamination Technician	2				2
Ambulance Driver			6		6
Messengers	1	1		1	3
Total	36	11	12	65	124

* This activation or reduced strength table is for the purpose of providing a workable organization with less effort on the part of the voluntary group charged with this responsibility.

MANNING TABLE OF A FIRST-AID STATION
(Disaster Status)*

Personal	*First Aid Station Group*	*Field First Aid Group*	*Ambulance Group*	*Litter Bearer Group*	*Total*
Physicians	3				3
Dentists or Veterinarians	2				2
Nurses	3				3
Nurses' Aides	8				8
Adm. Asst. or Pharmacist	1				1
First-Aid Technicians	20	27			47
Orderlies	14		19		33
Litter Bearers				105	105
Chaplain	1				1
Clerks	3				3
Decontamination Technician	2				2
Ambulance Driver			16		16
Medical Regulator			1		1
Messengers	2	1	2	2	7
Total	59	28	38	107	232

*The difference between this table and the activation table is mainly in the field first-aid and litter bearer groups who can be added and trained within a very short period following alert status.

The following manning table is suggested for use in the organization of the improvised hospital.

MANNING TABLE—200 BED IMPROVISED HOSPITAL

Administrator	1	Records Chief	1
Asst. Administrator	1	Supply Chief	1
Physicians	14	Transportation Chief	1
Dentists	3	X-Ray Technicians	2
Pharmacists	1	Housekeeping and Laundry Chief	1
Clergy	1	Dietitians	2
Nurses (registered)	25	Social Service	1
Nurses (practical)	20	Engineer	1
Nurses' Aides	20	Sanitarian	1
Anaesthetists	2	Laboratory Technicians	4
Information and Communication Chief	1	Miscellaneous	140
Registrar and			
Total			244

To include supply personnel, ward orderlies, clerks, typists, carpenters, cooks, cooks' helpers, maintenance personnel, utility personnel, unskilled laborers, etc.

COMMITTEE ON NECROLOGY

The "Committee on Necrology" was born at the 1952 meeting of the House of Delegates of the Illinois State Medical Society.

This Committee has sad duty of compiling and keeping a record of the passing away of its members during the past year, and reporting to the House of Delegates at the Annual Meeting. This duty formerly fell on the shoulders of the Secretary of the Society; it will now relieve that officer of a large amount of detail.

It has been necessary to review all obituary lists from all newspapers and publications over the state and to procure the names and dates of their passing away and arrange them alphabetically.

From January 1, 1952 to April 1, 1953, there were 188 deaths listed among our members. If the Committee has missed some names not on these lists, we would appreciate being notified so that their names may be listed at a subsequent time.

Unfortunately the deaths of many of our members are not reported to the Secretary's office for as long as two years after their passing. The Committee on Necrology wishes to urge all county society officers to correct this situation by mailing death notices promptly.

The Committee wishes to acknowledge and express its appreciation to the assistants in the Secretary's office for their untiring efforts in keeping the list up to date; it would have been impossible for the Committee to have done this without their constant vigilance.

A list of our members who have passed away since January 1, 1952 follows this report.

Respectfully submitted, ROBERT H. HAYES, M.D., *Chairman,* OSCAR HAWKINSON, M.D., E. H. WELD, M.D., *Committe on Necrology.*

William G. Alexander, Peoria, died June 14, 1952, aged 81.

Lee G. Allen, Litchfield, died June 11, 1952, aged 75.

William G. Allen, Evanston, died June 20, 1952, aged 78.

Guy L. Armstrong, Taylorville, died June 27, 1952, aged 73.

Charles W. Bailey, Hebron, died September 7, 1952, aged 77.

Waldo Brown Baird, Mt. Carmel, died October 17, 1952, aged 69.

William Hayden Baker, Quincy, died September 24, 1952, aged 82.

Lewis Daniel Barding, Moline, died April 14, 1953, aged 65.

Carl Beck, Chicago, died July 21, 1952, aged 88.

James Edward Bellinger, Collinsville, died June 17, 1952, aged 59.

George Seymour Betts, Banner, died April 27, 1952, aged 82.

Robert Webster Binney, Granite City, died October 28, 1952, aged 79.

John W. Blair, Homewood, died November 18, 1952, aged 76.

N. Lionel Blitzsten, Chicago, died September 27, 1952, aged 59.

Thomas Barrett Boland, River Forest, died February 21, 1952, aged 67.

John Thomas Boswell, Kewanee, died July 19, 1952, aged 63.

Londus B. Brannon, Manhattan, died December 1, 1952, aged 51.

Benjamin W. Breister, Chicago, died July 5, 1952, aged 59.

Alan G. Brooks, Robinson, died September 25, 1952, aged 66.

William L. Brown, Jr., Chicago, died July 11, 1952, aged 34.

Edward A. Brucker, Chicago, died May 1952, aged 63.

Roy A. Buckner, Gilman, died January 15, 1952, aged 70.

Alexander W. Burke, Cameron, died March 5, 1953, aged 68.

Clark A. Bushwell, Chicago, died February 9, 1953, aged 82.

Leo K. Campbell, Chicago, died June 13, 1952, aged 52.

Harry E. Canfield, Rockford, died September 30, 1952, aged 77.

Thomas J. Carmody, Danville, died July 27, 1952, aged 69.

Frank J. Chmelik, Joliet, died December 8, 1952, aged 61.

Archibald Church, Chicago, died May 8, 1952, aged 91.

Robert Clements, Danville, died October 14, 1952, aged 75.

John J. Coady, Minook, died October 10, 1952, aged 72.

Michael M. Cody, Elmhurst, died September 1, 1952, aged 63.

Trovalo C. Coggeshall, Henry, died March 23, 1952, aged 71.

Elmer E. E. G. Collins, Chicago, died May 16, 1952, aged 68.

George S. Connelly, Mount Pulaski, died November 23, 1952, aged 73.

Edgar C. Cook, Mendota, graduate of Harvard, 1917, was the son and grandson of physicians, both of whom were very active in the affairs of the Illinois State Medical Society. He was elected to the Council from the Second District in 1933, and remained in that office until he resigned on account of ill health in 1947. He was a regular attendant of meetings of the Council and at the Annual Meetings, and served faithfully over the period of years. Doctor Cook died February 6, 1953, aged 63.

Jacques Cooper, Chicago, died May 9, 1952, aged 62.

Wilbur E. Coulter, Seneca, died July 25, 1952, aged 69.

Edwin W. Wallace Crum, Waverly, died February 13, 1952, aged 71.

Clement Anthony Cummings, Wilmette, died February 26, 1953, aged 59.

John A. Dagnault, Rockford, died February 1953, aged 69.

Ulysses G. Darling, Chicago, died December 15, 1952, aged 86.

Frank N. Davenport, Moline, died February 3, 1953, aged 68.

Elias L. Davis, Peoria, died November 9, 1952, aged 84.

Don Deal, Springfield, died September 13, 1952, aged 73. Vice President of the Illinois State Medical Society in 1942.

Amos DeFeo, Chicago, died October 30, 1952, aged 62.

Carl C. Dillon, Sidell, died 1952, aged 73.

John H. Donovan, Windsor, died February 5, 1953, aged 86.

Maggie Yelton Downs, Danville, died September, 23, 1952, aged 85.

Benjamin Q. Dysart, Henry, died July 29, 1952, aged 59.

Harold Earnhart, Wilmette, died February 7, 1953, aged 49.

Fred J. E. Ehrmann, LaGrange, died July 16, 1952, aged 79.

Joseph Eisenstaedt, Chicago, died December 18, 1952, aged 67.

Matt Elson, Winnebago, died November 2, 1952, aged 65.

William G. Epstein, Chicago, died June 16, 1952, aged 65.

Charles G. Farnum, Peoria, graduated at Rush Medical College in 1901, died April 25, 1952, aged 77. Doctor Farnum was First Vice President of this Society in 1937, following a very successful meeting in Peoria for which he was General Chairman of the Committee on Arrangements. For a number of years he was designated at the "Poet Laureate" of the Illinois State Medical Society and contributed a page of his favorite poems for each issue of the Illinois Medical Journal. He was ever active in the affairs of his local Society and the Illinois State Medical Society.

Clara Ferguson, Gibson Island, Maryland, died June 21, 1952.

Frederick P. Foster, Chicago, died May 17, 1952, aged 93.

Charles P. Galanti, Chicago, died August 7, 1952, aged 47.

George Galloway, Chicago, died September 1, 1952, aged 85.

Donald M. Garcia, Bloomington, died 1952, aged 43.

Andrew Cosmos Garvy, Chicago, died September 1, 1952, aged 73.

Joseph A. Gazda, Chicago, died April 8, 1952, aged 70.

Melinda C. K. Germann, Quincy, died July 15, 1952, aged 88.

George E. Gilman, Streator, died December 16, 1952, aged 43.

James E. Goodman, Pleasant Hill, died January 11, 1953, aged 69.

Frederick Goodwin, Bloomington, died February 11, 1952, aged 77.

T. J. H. Gorell, Coral Gables, Florida, died April 14, 1952, aged 81.

Nathaniel A. Graves, Kirkland, died February 15, 1953, aged 89.

John W. Gray, Geneva, died April 23, 1952, aged 51.

Warner A. Gray, Metropolis, died February 4, 1953, aged 51.

William E. Guinea, Chicago, died November 22, 1952, aged 60.

Albert W. Haeffner, Melrose Park, died November 4, 1952, aged 72.

William N. Hamilton, Odin, died November 1952, aged 85.

John Ruskin Hawkins, Elmhurst, died July 15, 1952, aged 54.

Joseph K. P. Hawks, Bloomington, died June 15, 1952, aged 78.

Leland G. Hedges, Oak Park, died July 31, 1952, aged 57.

Berent Henrickson, Chicago, died April 17, 1952, aged 72.

Rudolph J. Hennemeyer, Chicago, died May 23, 1952, aged 56.

Charles Owen Hershey, Chicago, died 1952, aged 64.

Charles O. Highsmith, West Union, died 1952, aged 63.

Frank Brooks Hiller, Pickneyville, died May 6, 1952, aged 71.

Ralph T. Hinton, Quincy, died December 19, 1952, aged 71.

Elza Elvis Holloway, Centralia, died May 15, 1952, aged 79.

Edward D. Howland, Chicago, died March 27, 1952, aged 94.

James Burnett Hundley, Danville, died June 28, 1952, aged 72.

Wentworth L. Irwin, Plymouth, died June 1952, aged 90.

Warren C. Ives, Rockford, died June 4, 1952, aged 60.

James Jenson, Saybrook, died March 16, 1952, aged 74.

Benson M. Jewell, Danville, died August 15, 1952, aged 72.

Minas Joannides, Chicago, died September 8, 1952, aged 57.

Grover Erman Johnson, Chicago, died April 25, 1952, aged 67.

John A. Johnson, Mt. Vernon, died 1952, aged 71.

Julius P. Kissell, Centralia, died June 4, 1952, aged 63.

Herbert W. J. Kramps, Chicago, died April 23, 1952, aged 44.

George F. Kristan, Chicago, died October 26, 1952, aged 45.

Arthur H. R. Krueger, Chicago, died January 31, 1952, aged 70.

Jacob G. Kulis, Chicago, died August 28, 1952, aged 75.

Walter John Kutas, Chicago, died November 30, 1952, aged 48.

Pauline E. Lange, Chicago, died June 17, 1952, aged 76.

Leo Carroll Larkin, Chicago, died August 24, 1952, aged 43.

Thomas Augustus Lawler, Taylorville, died June 17, 1952, aged 76.

Earl C. Lawry, Earlville, died February 28, 1953, aged 77.

William W. Leake, Chicago, died August 26, 1952, aged 68.

Cuthbert J. Leavy, Freeport, died 1952, aged 77.

Werner Lonsen, Chicago, died February 8, 1953, aged 61.

Henry E. Lutyens, Los Angeles, California, died 1952, aged 67.

William Davis Madison, Peoria, died April 28, 1952, aged 69.

William A. Malcolm, Peoria, died July 19, 1952, aged 57.

George Marchmont-Robinson, Homewood, died June 14, 1952, aged 67.

Donian R. Martin, Mt. Vernon, died 1952, aged 45.

George H. Martin, Chicago, died June 27, 1952, aged 69.

Samuel E. Matzke, Warsaw, died April 2, 1952, aged 79

Charles E. Mayos, East Moline, died December 19, 1952, aged 74.

Edward C. Meyer, Chicago, died August 27, 1952, aged 59.

Alonzo Middleton, Clermont, Florida, died 1952, aged 77.

Bronislaus J. Mix, Chicago, died August 27, 1952, aged 57.

Gustav H. Moldenhauer, Chicago, died May 17, 1952, aged 77.

Amos Moore, Dixon, died January 2, 1953, aged 86.

Garfield B. Moore, Chicago, died July 9, 1952, aged 65.

Charles Edwin Morgan, Mattoon, died 1952, aged 82.

David Law Murphy, Dixon, died September 30, 1952, aged 50.

Brooks Jesse Musselwhite, Westmont, died April 20, 1952, aged 63.

Victor A. McClanahan, Aledo, died 1952, aged 83.

Silas Edward McClelland, Decatur, died 1952, aged 83.

William Aloysius McGuire, Chicago, died March 8, 1953, aged 63.

Robert C. McMillan, Monmouth, died April 13, 1952, aged 89.

Walter H. Nadler, Chicago, died September 14, 1952, aged 63.

Irving Newcomer, Petersburg, died July 1952, aged 81.

George C. O'Brien, Chicago, died October 3, 1952, aged 77.

John C. O'Connell, Rantoul, died July 11, 1952, aged 63.

Peter Paul O'Connor, Chicago, died December 11, 1952, aged 60.

Maurice C. O'Hern, Chicago, died July 24, 1952, aged 74.

Olaf Alfred Olson, Rockford, died February 27, 1952, aged 81.

Herbert E. Parsons, Decatur, died October 22, 1952, aged 68.

Evans W. Pernokis, Chicago, died November 9, 1952, aged 54.

Andrew Athanasios Petrakos, Chicago, died November 28, 1952, aged 54.

Floyd C. Phillips, Arthur, died April 13, 1952, aged 74.

Leopold H. Pijan, Chicago, died March 29, 1952, aged 73.

Lawrence Philip Piper, Chicago, died April 18, 1952, aged 68.

Maxim Pollak, Memphis, Tennessee, died November 20, 1952, aged 62.

Carl M. Ranseen, Rockford, died August 30, 1952, aged 73.

Maurice John Reilly, Arthur, died May 21, 1952, aged 47.

John J. Rendleman, Cairo, died October 11, 1952, aged 89.

Ora M. Rhodes, Bloomington, died December 4, 1952, aged 82.

Arthur J. Richter, Chicago, died October 3, 1952, aged 74.

Roy Otis Riser, Park Ridge, died January 3, 1952, aged 45.

John P. Roark, Chicago, died 1952, aged 89.

Louis S. Robins, Chicago, died January 8, 1953, aged 55.

George William Ross, Watseka, died February 9, 1952, aged 68.

Joseph W. Russell, Chicago, died March 19, 1952, aged 76.

Robert H. Saunders, Chicago, died December 23, 1952, aged 71.

Leo Saxon, Chicago, died April 29, 1952, aged 59.

Robert Schafer, Chicago, died May 1, 1952, aged 53.

Mary Gritzner Schroeder, Wilmette, died November 16, 1952, aged 83.

Leigh E. Schwarz, Chicago, died June 23, 1952, aged

Hiram Septow, Chicago, died July 7, 1952, aged 62.

Roy Sexton, Streator, died January 2, 1953, aged 84.

Earl W. Shaffer, Chicago, died September 2, 1952, aged 59.

Walter W. Silberman, Chicago, died 1952, aged 53.

Charles A. Sima, Oak Park, died December 9, 1952, aged 64.

Howard Sloan, Chicago, died 1952, aged 37.

Arthur A. Small, Chicago, died August 18, 1952, aged 79.

Alva Boyd Sowers, Chicago, died August 31, 1952, aged 68.

Arthur Sprenger, Peoria, died May 21, 1952, aged 63. Was Vice President of the Illinois State Medical Society in 1940.

Harry M. Steen, Springfield, died September 5, 1952, aged 47.

Benjamin J. Stevenson, Sparta, died March 8, 1952, aged 78.

Charles R. Summers, Oak Park, died June 11, 1952, aged 55.

Jesse C. Sutherland, Sparta, died November 8, 1952, aged 71.

Arthur W. Swift, Belvidere, died 1952, aged 93.

Elza F. Tate, Plainfield, died December 12, 1952, aged 65.

Louis N. Tate, Galesburg, died June 12, 1952, aged 75.

Charles C. Thomas, Chicago, died October 30, 1952, aged 72.

Leon V. Urbanowski, LaSalle, died September 18, 1952, aged 61.

James A. Valentine, River Forest, died December 30, 1952, aged 65.

William Crowell VanBenschoten, Chicago, died October 21, 1952, aged 82.

Raymond Fleming VanDoren, East Lynn, died May 5, 1952, aged 65.

Bertha VanHoosen, Chicago, died June 8, 1952, aged 89.

Frank L. Wakefield, Heyworth, died September 29, 1952, aged 85.

Olin West, Chicago, died June 20, 1952, aged 77. For many years he was Secretary and General Manager of the American Medical Association.

Joseph E. Westerlund, Cambridge, died September 6, 1952, aged 82.

Charles E. Wilkinson, Danville, Councilor for the Eighth District of the Illinois State Medical Society from 1934 to 1946 when he was compelled to retire on account of his health. Doctor Wilkinson had been very active in the Illinois State Medical Society for a period of fifty years. Active in his county society throughout his professional career, and always anxious to help younger men become established in their respective locations in his area. Was a delegate from this Society to the A. M. A. for many years until his retirement. He was a member of the Fifty Year Club of the Illinois State Medical Society. His death occurred August 15, 1952, at the age of 83.

David A. Willis, Chicago, died May 20, 1952, aged 52.

Julius Henry Wilson, Chicago, died June 26, 1952, aged 73.

William H. Wilson, Sr., Danville, died 1952, aged 70.

Matthew W. Withers, Joliet, died January 1, 1953, aged 61.

Clayton S. Whitehead, Naperville, died November 1952, aged 74.

DR. ROBERT H. HAYES: On pages 153-158 of the Handbook you will find a list of those who departed in 1952 and up to April 1, 1953.

I have 18 more names to add to the 178 in the Handbook.

SUPPLEMENTARY REPORT OF COMMITTEE ON NECROLOGY

The following deaths have been reported to the Office of the Secretary since the report of this Committee was sent to the printer for publication in the handbook.

Blount, Anna E.	Oak Park	Died Feb. 12	Age 81
Brown, Edward V. L.	Winnetka	Died March 1	Age 77
Ford, Charles	Hillsboro	Died April 27	Age 70
Forkosh, Sydney R.	Chicago	Died March 1	Age 47
Fox, Noah	Chicago	Died April 9	Age 58
Hallmann, Alfred H.	Chicago	Died Feb. 15	Age 55
Herndon, Richard F.	Springfield	Died Feb. 1953	Age 63
Herrmann, Ross E.	Bradford	Died April 21	Age 46
Hellister, Bruce A.	West Chicago	Died March 1	Age 64
*Holmes, Rudolph W.	University, Va. (Formerly Chicago)	Died April 25	Age 80
Jones, William M.	Chicago	Died April 21	Age 55
Lennarson, Vincent A. E.	Waukegan	Died Feb. 28	Age 41
Litt, Sol	Chicago	Died April 6	Age 53
McNattin, R. F.	Chicago	Died May 9	Age 50
Richardson, Garwood C.	Chicago	Died March 4	Age 56
Schuette, William H.	Mason City	Died ?	Age 81
Stein, William C.	Chicago	Died Feb. 15	Age 61
Vainisi, Salvatore A.	River Forest	Died Feb. 20	Age 50
Xavier, Frank K.	Chicago	Died April 17	Age 54

*Professor of Obstetrics and Gynecology at Rush Medical College for more than 30 years. Associate Professor in Ob and Gyn at Northwestern University Medical School. Bequeathed entire estate to a trust to be used for reduction of infant mortality.

THE PRESIDENT: That will go to Committee "B".

DR. HAYES: Mr. President, I would like to move that the House of Delegates stand in silent tribute for at least one minute for those who departed during the past year. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried.)

COMMITTEE ON NURSING

The Committee on Nursing held three meetings during the past year; all members were present at all meetings. This committee has maintained a close liaison with the Co-ordinating Committee on the Nursing Problem of the Chicago Medical Society and with the A. M. A.

This committee has been represented at the monthly board meetings of the Chicago Council on Community Nursing, the Committee on Careers in Nursing, Illinois League for Nursing, etc. The Committee was also represented at the 14-State Conference on Nursing Problems held at Kansas City, Kansas on September 28, 1952 and March 1, 1953.

The National Accrediting Service released in August 1952 a list of Schools approved for full accreditation. Twenty-eight of the 84 schools of nursing in the State of Illinois were not accredited; six of the twenty-eight schools did not apply for accreditation.

	Schools	*Accredited*	*Not Accredited*
Chicago	34	25	9
County excluding Chicago	7	7	0
Rest of State	43	24	19
Totals	84	56	28

In an effort to do everything possible to aid in the training of future nurses, your committee met with Miss Helen Nahm, Director of the National Accrediting Service in Chicago, on February 13, 1953. Miss Nahm outlined the history of the accreditation program and answered many questions. Most of the Chicago hospitals that were not accredited have either closed or are in the process of being examined again. She was unable to tell us what is happening to the downstate hospitals.

The national nursing organizations have been consolidated into two national organizations, the American Nurses Association and the National League for Nursing. In Illinois the nursing organizations are the Illinois State Nurses Association and the Illinois League for Nursing.

The shortage of nurses is still acute. Your committee has prepared charts showing the capacity of 3 year schools of nursing in Illinois. The first chart shows the maximum number of students that could have been admitted, the number admitted and the percentage admitted. The second chart shows the total capacity for all three years of the schools of nursing, the number of students now enrolled, and the percentage enrolled.

1952 Admissions in 3-year Schools of Nursing in Illinois.

	Spring Class		*Fall Class*	
	Maximum	*Present*	*Maximum*	*Present*
Chicago	314	168 (54%)	1374	1118 (81%)
Downstate	37	12 (32%)	1837	1481 (81%)
	351	180 (51%)	3211	2599 (81%)

1952 Enrollment in 3-year Schools of Nursing in Illinois

	Maximum	*Present*
Chicago	4226	3205 (76%)
Downstate	4710	3815 (81%)
Totals	8936	7020 (79%)

Your committee has also prepared charts showing the admissions and enrollment of 1952 compared with 1951.

Fall Admissions

	1951	1952	
Chicago	1067	1118	(plus 51)
Downstate	1481	1481	(no change)
Totals	2548	2599	(plus 51)

Total Enrollment

	1951	1952	
Chicago	3187	3205	(plus 18)
Downstate	4048	3815	(minus 233)
Totals	7235	7020	(minus 215)

We wish to call attention to the fact that although the number of students has increased by 51, the total enrollment has decreased by 215 students.

At present four schools of nursing have closed, the Mother Cabrini Hospital School of Nursing and the Garfield Park Hospital School of Nursing in Chicago, Southern Illinois University School of Nursing at Carbondale and the Sherman Hospital School of Nursing at Elgin.

An eight day course in the nursing care of the patient with Poliomyelitis was given at the University of Illinois from March 30 to April 8, 1953. It was well attended by instructors, supervisors and nurses from almost every part of Illinois.

The practical nurse program has shown a marked increase during the past year. The two schools in Chicago, the Princeton and Manley offering practical nurse training courses have been filled to capacity. Another school will soon offer similar courses, it is the Greeley Vocational School and is located on the north side. Two schools have opened in the downstate area and are showing good progress.

This committee hopes that some of the hospitals in the State of Illinois will establish approved schools of practical nursing. The committee feels that the hospital atmosphere would be very valuable to practical nurses in training.

Respectfully submitted, M. M. HOELTGEN, M. D., *Chairman,* FRED H. MULLER, M. D., P. P. YOUNGBERG, M. D., JOHN L. REICHERT, M. D., *Committee on Nursing.*

COMMITTEE ON NUTRITION

The Committee on Nutrition of the Illinois State Medical Society held its first meeting after appointment June 30, 1952. This meeting was held at the University of Illinois Medical School and was in conjunction with a meeting of the Friends of the Land, a non-profit organization devoted to the conservation of natural resources and the better health of the people through proper nutrition. Various means were discussed by which the subject of Nutrition could best be brought to the attention of practicing physicians and medical students. Among those attending the meeting were Doctors Carlos P. Reid, Physiologist at the University of Illinois Medical School, John J. Miller, an investigator, working in trace minerals, Jonathan Foreman, editor of the Ohio State Medical Journal. These gentlemen have been most helpful and have spent considerable time advising the Committee on Nutrition.

Early in the Fall Dr. Lee Hoyt, Chairman of the Committee, and I attended the session of the Illinois State Nutrition Society in Springfield. Due to Dr. Hoyt's recent illness I have been asked to carry on the activities of the Nutrition Committee as co-chairman. On December 4, 1952, Dr. Hoyt and I met and reviewed the aims and purposes of the Nutrition Committee. In order to further acquaint myself with the functions of the Committee, I have spent time with Dr. James R. Wilson, Secretary to the Council on Foods and Nutrition of the American Medical Association. Dr. Wilson has given willingly of his time and knowledge to orient me in this field.

We planned to include at the Annual Convention of the Illinois State Medical Society a symposium on Nutrition. We had secured as speakers for this symposium Dr. William Darby, Vanderbilt Medical School, Nashville, Tennessee; Dr. Clifford J. Barborka, Northwestern University, Evanston; and Dr. James R. Wilson, Secretary of the Council on Foods and Nutrition of the American Medical Association. Dr. Theodore Van Dellen had again consented to preside at the symposium as he did last year. Due to conditions beyond our control it was necessary to cancel these plans.

Other activities which the Committee on Nutrition should participate in are: (1) Representation at meetings with recognized conservation and public health groups. (2) Physicians qualified to speak on Nutrition should be encouraged to appear before both medical and lay groups in the interest of a better knowledge of health and nutrition. The interest in good nutrition from the soil to ultimate consumption of food is everybody's business. The medical profession should be alerted to the increasing role nutrition will play in the practice of medicine in the future. The race is assured of survival by means of anti-biotics and blood. The question next to be answered is: "How healthy can we survive?" Proper nutrition offers the answer to this question.

Respectfully submitted, PAUL A. DAILEY, M. D., *Chairman,* LEE T. HOYT, M. D., *Co-Chairman,* G. C. OTRICH, M. D., WARNER H. NEWCOMB, M. D., JOHN P. O'NEIL, M. D. *Committee on Nutrition.*

COMMITTEE ON PHYSICAL MEDICINE AND REHABILITATION

The Committee on Physical Medicine and Rehabilitation has regularly furnished abstracts of the writings on Physical Medicine and Rehabilitation to the Illinois Medical Journal. The current literature has been reviewed and significant material has been selected.

Respectfully submitted, EMIL D. HAUSER, M. D., *Chairman,* H. WORLEY KENDALL, M. D., DISRAELI W. KOBAK, M. D., STERLING PARKER, M. D., RICHARD J. BENNETT, JR., M. D., *Committee on Physical Medicine and Rehabilitation.*

COMMITTEE ON POSTGRADUATE EDUCATION

The Committee on Postgraduate Education has held six meetings during the year. The high points of its activities may be thus summarized:

1. The Committee has presented nine major conferences throughout the State. Programs were all of high quality. Attendance ranged from mediocre to excellent. Three smaller meetings were held.

2. The Committee brought together in one meeting representatives of the medical schools in Chicago, professional societies and voluntary agencies to discuss cooperation, synchronization and other problems of postgraduate programs.

3. The Committee, with the authorization of the Council, has taken an active part in the organization of a national group of postgraduate committees, known as the States' Medical Postgraduate Association. The chairman is its first president.

4. Also with the approval of the Council, the Committee has undertaken to raise funds and make a detailed survey of postgraduate education in Illinois.

These various activities may be summed up thus:

Postgraduate opportunity is needed and wanted by physicians throughout the state, and we are therefore continuing the established procedure of past years, but a thorough study of the problem is essential in order to reformulate our program so as to make the best possible use of available teachers' time, to avoid competition and duplication and render the greatest service to our members and thereby to the public.

One other development should be mentioned. By authority of the Council, responsibility for the heavy detail involved in the postgraduate program has been placed in the office of James C. Leary, director of public relations, and he has been named secretary to this Committee.

A more detailed report of our activities follows:

1. Following is the list of cities in which postgraduate conferences have been held, or are scheduled at this writing, the host county society, and the medical school or hospital staff supplying the speakers:

MAJOR CONFERENCES

Date	City	Host Society	Faculty
Nov. 20	Peoria	Peoria County	Northwestern University Medical School.
Dec. 10	Joliet	Will County	University of Illinois College of Medicine.
Jan. 28	Cairo	Alexander County	Wesley Memorial Hospital.
Mar. 10	Rockford	Winnebago County	University of Chicago School of Medicine.
Mar. 19	Quincy	Adams County	Cook County Hospital.
April 2	Centralia	Marion County	Stritch School of Medicine of Loyola University.
April 9	Champaign	Champaign County	Chicago Medical School.
April 30	Springfield	Sangamon County	Presbyterian Hospital.
May 7	Mattoon	Coles-Cumberland County	St. Luke's Hospital.

SMALL CONFERENCES

?????	Chester	Randolph County	3 selected speakers.
Mar. 19	Murphysboro	Jackson County	3 selected speakers.
April 15	Lawrenceville	Lawrence County	3 selected speakers.

The Council originally authorized fifteen major conferences to be given by the five medical schools and ten large hospitals, together with twenty small conferences, each with three selected speakers. Several complications, however, prevented carrying out the program in full. First, the preliminary planning and authorization, plus the setting of dates by agreement among councilors, county societies and the secretary's office came late in the autumn, so that many available dates were not used. Then it was decided, on the basis of experience, not to stage any meetings in January and February, because of the uncertainty of the weather. Only one meeting, already set up when the decision was made, was held in that whole period. The fact that the winter was unusually open is not a valid argument against that decision. Third, it was necessary to cancel out several dates, notably Jacksonville, Benton and Rock Island, because they conflicted with other meetings.

Regarding the small conferences, the same factors operated. Several which had been scheduled were dropped because of various conflicts. A letter to Councilors later asking for dates brought only three replies.

With regard to these conferences, the Committee recommends:

a) That the major conferences be continued pending the proposed comprehensive survey of the program.

b) That the smaller conferences be similarly continued as an extremely valuable method of teaching which has not yet had adequate trial in Illinois.

c) That, in any event, the program be set up this spring for next year, including the budget appropriation, in order to avoid unduly taxing our facilities and to make the whole complex mechanism underlying this program more efficient. More time to plan and execute and publicize means better and more satisfactory conferences.

To implement the last recommendation, the Council has approved the idea of expanding this Committee so as to include a representative from every Councilor District, each to be responsible for setting conference dates and places in cooperation with the Councilor. The additional men are now being sought.

Nearly one hundred practicing physicians were involved in these programs, who gave as much as two days of their time to make them possible. The Committee wishes to take this opportunity to express the gratitude of the Society to all of them. We owe them much.

2. The meeting of agencies interested in postgraduate education in Illinois, held June 5, 1952, was attended by representatives of three medical schools and two other teaching groups, nine medical organizations, two official bodies and eight voluntary agencies. (Their names are given in Appendix B.)

The discussion was free and lengthy. The group adopted a resolution "that there is a need for expansion and co-ordination of the over-all postgraduate education picture in Illinois" and another to the effect that representatives of the various agencies be organized into an advisory group of this Committee which should act toward "co-ordination and as an information center."

3. The States' Medical Postgraduate Association was formulated in June, 1952, with the American Medical Association in advisory cooperation. Two more meetings will be held during the June, 1953, meeting of the A. M. A. in New York, at one of which the Committee on Continuation Education of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the A. M. A. will be represented. A constitution has been prepared and the group incorporated.

The Illinois and the national meetings, taken together, reflect a growing sentiment for a re-study of the whole medical postgraduate picture. Every organization interested in the field is affected, and Illinois, which has one of the larger programs among state medical societies, should be and is deeply concerned. Many questions have been raised. Who is basically responsible for providing postgraduate opportunity—organized medicine, the medical schools, government agencies, medical specialty groups, voluntary agencies? Should a fee be charged? Is the day-long meeting such as ours

the best method of presentation? Should teachers instead spend a week at a time in a hospital, analyzing local material and lecturing? Should "circuit-riders" be kept on the road? Is a telephone round-table hookup a satisfactory method? Will TV educational channels be allotted to medical teaching? Should meetings last several days? What subjects should be covered and who is to select them? Can attendance at home county meetings, or at one-week or two-week courses in medical schools be made obligatory? What is the extent of the need and where is it acute?

These are not academic questions, but highly apropos. The medical educators—at least many of them—believe that teaching should be more intensive and that teachers' valuable time is often wasted in traveling many miles to talk to small audiences. They want to know the facts in order to decide what must be done and to do it with the greatest possible return.

4. It was with these problems in mind that your Committee suggested to the Council the importance of a careful survey of the situation in Illinois. We need answers if we are to get the most value from our funds and energies. Such a study would be important to us as a basis for planning a co-ordinated and expanded program, but it would also be of national value. The Council agreed and we are now trying to raise funds—some $10,000 in all—among the numerous organizations interested. We believe the money will be forthcoming, but are not able to report details, as the work is only now starting. The Council has approved the use of any money remaining in this year's budget to pay part of the cost of this survey.

The Committee recommends further therefore:

d) That the House of Delegates likewise approve the plan for a survey of postgraduate medical education in Illinois.

The Committee has, of course, worked closely with the Council on this important subject, one of the prime purposes of medical organization, with far-reaching implications for the public welfare and medical progress. In closing, therefore, we take this opportunity to express our deep appreciation for the sympathetic hearing and earnest cooperation we have always encountered when we take our problems to that body. The secretaries of county societies, who make local arrangements, also deserve commendation.

Respectfully submitted, GEORGE A. HELLMUTH, M.D., *Chairman,* F. GARM NORBURY, M.D., FRANK DENEEN, M.D., R. C. OLDFIELD, M.D., N. C. BARWASSER, M.D., W. W. FULLERTON, M.D., GEORGE KIRBY, M.D., MAX SAMTER, M.D., ARKWELL M. VAUGHN, M.D., JAMES C. LEARY, *Secretary, Committee on Postgraduate Education.*

APPENDIX B.

Agencies represented at meeting held June 5, 1952, to discuss postgraduate education in Illinois were:

Medical Schools and Teaching Groups:
- Stritch School of Medicine, John F. Sheehan, M.D.
- University of Illinois, Stanley W. Olson, M.D.
- Chicago Medical School, F. J. Mullin, M.D.
- Michael Reese Hospital, Samuel Soskin, M.D.
- Cook County Graduate School, John B. O'Donoghue, M.D.

Medical Organizations:
- Postgraduate Education Committee, George A. Hellmuth, M.D., Frank Deneen, M.D., W. W. Fullerton, M.D.
- Chicago Medical Society, Walter C. Bornemeier, M.D.
- Illinois Academy of General Practice, H. Marchmont Robinson, M.D., A. Doktorsky, M.D., Maynard Shapiro, M.D.
- American College of Chest Physicians, Edward R. Levine, M.D.
- Chicago Allergy Society, Ben Z. Rappaport, M.D.
- Chicago Gynecological Society, Edwin J. De Costa, M.D.
- American College of Surgeons, Paul R. Hawley, M.D.
- American Medical Association, Donald G. Anderson, M.D., Francis R. Manlove, M.D.
- Chicago Hospital Council, Stephan Manheimer.

Official Bodies:
- State Health Department, Charles F. Sutton, M.D.
- Chicago Board of Health, Frank V. Meriwether, M.D.

Voluntary Agencies:
- Illinois Heart Association, Thomas Austin, Marguerite L. Ingram.
- Chicago Heart Association, Josephine Bessoms, Florian E. Schmidt, M.D.
- Illinois Tuberculosis Association, Ellsworth R. Thwing.
- Arthritis and Rheumatism Foundation, Carl Harris, Normal Spalding.
- Cerebral Palsy Association of Illinois, C. J. Connelly.
- American Cancer Society, John A. Rogers, M.D.
- National Foundation of Infantile Paralysis, W. M. Runyon.
- Tuberculosis Institute of Chicago and Cook County, John E. Egdorf.

COMMITTEE ON RURAL MEDICAL SERVICE

Since the last session of the House of Delegates, the Committee on Rural Medical Service has concentrated on only two items. Whenever we could at all be helpful, we have tried to improve the status of County Health Improvement Associations. The number of such County Associations has increased

in the last 12 months, and the number of farm families insured under the program has quite appreciably increased. The County Health Improvement Associations have certainly done an excellent job for the rural citizens of our state and have done probably a better job than a health council could have done. Over 150,000 farm families in Illinois are now covered with Blue Cross hospital protection. As an example of the various health activities these County Associations take up, nurses training programs appear to head the list. Blood typing, eye testing, the testing of water supply, and Brucellosis control are examples of what County Health Improvement Associations are doing.

Through the mechanism of Health Improvement Associations, loyalties to family and community responsibilities toward our neighbors are being emphasized. A considerable amount of understanding of public health problems and prevention programs is evidenced. The enthusiasm of the citizens of the various counties towards all these projects is most commendable, and we in medicine must encourage such activity as much as humanly possible.

The members of the Farmer-Doctor Loan Fund Board, which was originally sponsored by this committee, met in Springfield with a joint committee appointed by the House and Senate to discuss the future of loan programs in Illinois. It was agreed by all present that the Illinois Agricultural Association and the Illinois State Medical Society's Loan Fund Board should continue to function. There are now 40 students in various phases of their medical education or military career who are enrolled in this program. One of these students failed to live up to his contract to return to his home county and practice, but did abide by the penalty provision of the contract and paid back his loan plus interest at 7%, and his contract was voided. The Loan Fund committee thinks this is a reasonably good record since only one in forty has failed to abide by the provisions of the contracts. There is never 100% satisfaction as to any loan program or admissions program for medical students, but there seems to be general feeling that our present arrangement in Illinois is as satisfactory as can be worked out.

Being near to the University of Illinois, the chairman has tried to help the Home Economics-Agricultural Extension Service at the University in developing programs aimed at the general improvement of rural health. The sincere cooperation of University personnel is certainly appreciated.

The chairman has answered many letters from a variety of sources during the year; Church groups, the National Child Labor Committee, the American Medical Association's Radio Committee headed by Dr. Bauer, and others have asked for a variety of assistance. The chairman has given assistance wherever reasonably possible and tried to intelligently answer the questions presented.

Respectfully submitted, HARLAN ENGLISH, M.D., *Chairman,* G. C. OTRICH, M.D., J. C. REDINGTON, M.D., W. I. LEWIS, M.D., *Committee on Rural Health.*

SCIENTIFIC SERVICE COMMITTEE

The Scientific Service Committee has endeavored during the past year to meet every request for service from the various county medical societies in the State. The following table is submitted to show the extent of services.

Societies	*Speakers*	*Double Postal Card Notices*	*Single Postal Card Notices*	*Press Releases*
Bureau	1	866		56
Coles-Cumberland	1			
Champaign	1			
DeKalb	10	510		88
Fulton	4			
Greene	1	431		76
Henry	5	822		94
Kane	3			
Kankakee	3			
Knox	8	413	853	82
LaSalle	3	1408		215
Logan	4		104	18
Macon	1			
Marion	1			19
McLean	2			
McDonough	5	389		282
Montgomery-Macoupin	2	144		32
Rock Island	1			
Whiteside-Lee	10	904		158
Will-Grundy	3			158
Total	69	5887	957	1120

Among the speakers scheduled were: Irwin Dritz, E. William Immermann, Carlos I. Reid, Ph. D., Harry A. Oberhelman, John A. D. Cooper, Robert Schmitz, Leander W. Riba, Walter J. Reisch, Wesley A. Gustafson, Manley A. Page, Charles S. Gilbert, Charles E. Galloway, Burton J. Winston, Erich M. Uhlmann, Edwin R. Levine, Chester C. Guy, Arthur J. Atkinson, Sidney A. Portis, David Markson, Albert H. Unger, Harry M. Hedge, Carl E. Billings, Hamper Kelikian, Edward E. Avery, Elizabeth A. McGrew, Albert Walter Wise, Howard A. Lindberg, Max M. Montgomery, Gerald M. Cline, Thomas C. Galloway, Harvey White, Roland P. Mackay, Robert M. Jones, Charles D. Krause, Willard C. Scrivner, Mitchell A. Spellberg, James H. Hutton, Edwin N. Irons, Gilbert H. Marquardt, Warren H. Cole, Harold C. Voris, Walter S. Priest, Felix A. Tornabene, Thomas H. Burford, Myron M. Hipskind, Thomas D. Masters, Willard Van Hazel, H. Close Hessel-

tine, Harry E. Mock, Jr., Patrick H. McNulty, Jerome T. Paul, Karl H. Pfuetze, Thomas J. Coogan, James H. Cross, August F. Daro, John L. Keeley, Marc H. Hollender, Matthew J. Brunner, William A. Larmon, Harvey S. Allen, Ralph Spaeth, Robert M. O'Brien, Carlo Scuderi, Lawrence Breslow, Alex J. Arieff, Ernest D. Bloomenthal, Fred H. Decker, Carl J. Marienfeld, Harry F. Dowling, Henry Buxbaum, James B. Waller, James J. Callahan, Jack W. Fischer, John Soukup, Louis R. Limarzi, Eric Oldberg, Steven O. Schwartz, Cleveland J. White, L. Martin Hardy, Frederick H. Falls, Paul K. Anthony, Willard M. Easton, John L. Reichert, Samuel L. Governale, Benjamin Pearlman, Chauncey Maher, George M. Cummins, and Max S. Sadove.

The sixty-nine speakers were scheduled for twenty-four societies, four of which meet jointly with one other society. In addition the Committee has completed the scheduling of seventeen speakers before seven of the county medical societies listed for the period beyond that covered by this report. In addition seven speakers were scheduled for the Stock Yards Branch to the Chicago Medical Society, three for the Illinois Chapter of the Academy of General Practice, one each for the Springfield Medical Club, the Roseland Community Hospital Staff and the Iowa-Illinois Central District Medical Association. Thus the grand total of speakers actually scheduled during the year ended April 1, 1953 is 98.

Three speakers were scheduled for a special meeting of the Knox County Medical Society to commemorate its 100th Anniversary. In addition two speakers were scheduled and postponed for rescheduling when the local society changed their plans. In one instance a community public meeting was scheduled the same evening which, it was believed, would detract from the regular meeting of the county medical society and one was rescheduled when the county medical society decided to devote its regular planned meeting to a ladies night.

The Scientific Service Committee held a meeting September 10, 1952, at the Sherman Hotel, the only meeting during the year. At that time a complete progress report was made to the members of the Committee by the Chairman. At that meeting the Chicago staff was instructed to resurvey the county medical societies similar to the study that was made in 1949. However, shortage of personnel in the Chicago office has made it impossible to initiate this project.

During the past year the Council authorized the Committee to revise the 1947 List of Speakers and the Supplementary List which was published in 1950 in mimeograph form. Again inadequate personnel prevented the fulfillment of these projects.

A subcommittee to the Scientific Service Committee was appointed to study the proposed revision of the List of Speakers. The development of a suitable format was the result. However, the project cannot be carried out until adequate personnel is available.

The Chairman has visited the Chicago office at least once a week during the past year to advise, counsel and direct any problems which developed within the Scientific Service Committee in filling its objective of rendering whatever assistance was requested by the individual county medical societies. In addition your Chairman has attended and presented progress reports to five meetings of the Council. It is a pleasure to report that many new secretaries and program chairmen visited the Chicago office to work out individual programs for their respective societies.

Acting under authorization from the Council the Scientific Service Committee continues to direct county medical societies to assume expenses for their individual speakers whenever possible. However, the Committee will continue to assume the expenses of those county societies whose treasuries cannot care for this expense.

In one instance during the past year the local county society indicated that it could not assume all the expenses for their regular monthly speakers, but indicated a wish to assume half of the expenses. This arrangement was approved by the Council.

The Scientific Service Committee respectfully submits this report in concise form. It recognizes that only a complete and detailed report could possibly cover the multitudinous details incidental to the scheduling of physicians, either by telephone or by correspondence, the sending of confirmation letters to both the speaker and the program chairman, and the preparation and mimeographing of postcard notices and newspaper publicity. Newspaper publicity is released only when the local society requests it and to the papers in the counties designated.

The Scientific Service Committee will continue to service groups other than county medical societies but only if the individual organization assumes expenses of the speaker.

In the past there have been physicians who have written to the county medical societies offering to participate in the society's program. The Council directed the Scientific Service Committee to discourage this approach. All physicians wishing to appear in the List of Speakers of the Scientific Service Committee are urged to submit their names and subjects. The Committee recognizes that many county medical societies wish to schedule their own speakers, but wishes to report to the House of Delegates that it stands ready and willing to service all county medical societies whenever assistance is requested.

The Scientific Service Committee wishes to point

out that several physicians have complained about the lateness of the hour at which they made their appearance on the program because of the business session of the county medical societies. The Committee wishes to urge all societies to present their speakers first on the program, whenever possible, to permit speakers to return to their homes at a reasonable hour.

The Scientific Service Committee wishes to acknowledge the services of the staff of the Educational Committee which carries on the work of this Committee. It wishes too to commend the staff for their efforts in carrying on the work of the Committee even though handicapped by shortage of personnel. In spite of the many problems that have arisen during the past year, there has been a harmonious attitude in the attempt to fulfill all obligations.

Respectfully submitted, LOUIS R. LIMARZI, M.D., *Chairman,* J. K. HANSON, M.D., WILLIAM H. WHITING, M.D., GILBERT H. MARQUARDT, M.D., JEROME T. PAUL, M.D., J. J. LINK, M.D., HARRY A. OBERHELMAN, M.D., CHARLES D. KRAUSE, M.D., *Scientific Service Committee.*

COMMITTEE ON TUBERCULOSIS CONTROL

Meetings were held by the Tuberculosis Control Committee of the Illinois State Medical Society on January 8, 1953 and March 27, 1953. A report was made to the February meeting of the Council of the Illinois State Medical Society. At the second meeting the problem of tuberculosis in the State of Illinois and its local communities was again reviewed with particular emphasis on the legislation introduced or about to be introduced to the 68th General Assembly of the Illinois State Legislature.

The tuberculosis mortality figures for the State of Illinois continue to show a satisfactory reduction. In 1950 there were 2,212 deaths from tuberculosis which is 25.3 per 100,000 population. The 1951 report indicates 1,806 deaths from tuberculosis in the State of Illinois which is 20.4 per 100,000. This compares with the national average of 21.4 per 100,000 for 1951. The majority of the deaths in the State of Illinois occurred in Chicago. The Chicago figures were 1,373 for the year 1950 or 37.7 per 100,000 population and in 1951 the Chicago fiures were 1,191 or 32.5 per 100,000. The corresponding downstate figures were 839 deaths from tuberculosis in 1950 or 16.5 per 100,000 and in 1951 the figures were 615 deaths or 11.8 per 100.00. The 1952 figures are not yet available. If we project the figures at the same rate of decline, we would have a mortality rate of 15.4 for the State; 27.5 for Chicago, and 6.8 for downstate Illinois in 1952. Since the mortality rate for Chicago in 1946 was 52 per 100,000 population the rate of decline is encouraging.

The morbidity rates have not shown a corresponding decline. This is to be expected since there has been a great deal of increased activity in finding tuberculosis among healthy people by surveys conducted by the Seal Sale Organizations, the Illinois Department of Public Health and local tuberculosis authorities. There were 240,150 x-rays taken in the downstate surveys and 616,500 in the Chicago area in 1952.

The total number of beds for tuberculosis in use in Chicago has not changed appreciably. One hundred new beds were added to the North Riverside Branch of the Municipal Tuberculosis Sanitarium and fifty beds were filled by tuberculosis patients at the Chicago Municipal Contagious Hospital. The commissioning of the Chicago State Tuberculosis Hospital beds has been delayed by unusual building difficulties encountered because of the Korean War. The projected date of opening is July 1, 1953. Because of the difficulty in acquiring new personnel during the war perior it is expected that not all of the 500 beds will be put in operation for a number of months.

The Suburban Cook County Tuberculosis Sanitarium District by hospitalizing the majority of their patients in private or municipal sanatoria outside of Cook County have freed almost 200 beds at the Oak Forest Tuberculosis Hospital which are now occupied by residents of the City of Chicago. The Suburban Cook County Tuberculosis Sanitarium District has also opened a 20 bed convalescent home for the care of chronic tuberculosis patients. Ground breaking ceremonies for a new 150 bed Tuberculosis Hospital will take place May 4, 1953 This will make an important contribution to the bed capacity for tuberculosis patients in the Chicago area.

It will probably be January, 1954, before the tuberculosis hospitals in the Chicago area are operating at full capacity. If to the projected figure of 2,700 official Chicago beds, we add the beds for tuberculosis patients at Hines Hospital, Downey Hospital and the various private sanatoria the total capacity will be from 3,300 to 3,500 beds. Chicago then for the first time in its history will have the accepted ratio of 3 to 3½ beds per death. There can be no doubt that future mortality statistics will reflect the continued efficient use of these beds.

The Illinois State Department of Public Welfare reports further decrease in its mortality figure from 319 deaths in 1946 to 94 in 1952, a decrease of 70%. Plans are under way for two new tuberculosis hospitals for mental patients. The Tuberculosis Program in the State Welfare Institutions has resulted in a gradual decrease in the incidence of new cases in their patient population. In 1945 there was a new case incidence rate of 1.9% while in 1952 this rate was only .26% of the institutional population.

In the Department of Public Safety the tuberculosis control among prisoners and prison employees continues to show satisfactory results, except at

the Illinois State Farm in Vandalia. Corresponding conditions in the Bridewell and Cook County Jails are also unsatisfactory. Since approximately 30,000 prisoners go through the Bridewell and Cook County Jails annually, it is obvious that adequate control measures should be instituted in these institutions in order to prevent the spread of tuberculosis among this population group. The committee commends this problem to the Tuberculosis Control Committee of the Chicago Medical Society.

The committee studied the Tuberculosis Bills submitted or to be submitted to the 68th General Assembly of the Illinois State Legislature.

House Bill 228, has been introduced and has passed its first reading. This bill amends certain section of the State Tuberculosis Sanatorium Law to provide more efficient management by the State Health Department by deleting the limitation of $6.00 in the charge for hospital care. This will give the Department of Public Health more flexibility in dealing with varied financial conditions of the tuberculosis authorities sending patients to Illinois State Tuberculosis Hospitals. It will also prevent unfair competition with other local private or public sanatoria. This bill provides that the Department of Public Health on its own initiative and at State expense may admit to State Sanatoria a transient tuberculosis patient of Illinois who has not established residence and who is suffering from tuberculosis in a form dangerous to the public health. The committee has studied this bill and recommends its endorsement.

House Bill 229, amends the State Tuberculosis Subsidy Law to increase the maximum amount of subsidy which the State may pay from $3.00 to $4.00 per day. The total amount of the subsidy remains at $5,000,000. A second amendment would limit amount of money to be spent by State subsidized sanatoria by maintenance, repair, alteration, rehabilitation and expansion of such sanatoria to not more than 10% of the total local tax levy for tuberculosis purposes. An additional section was added so that the State Health Department may use maximum of 5% of the funds for carrying out the provisions of this Act to supplement payment for qualified local authorities in any case where the combined funds from local taxes and State aid are not sufficient to pay the cost of sanatorium care for all residents who are suffering from tuberculosis within such jurisdiction. Provision is also made authorizing the State Health Department to pay the costs of sanatorium care for transient persons who have no established residence and who are suffering from tuberculosis.

Senate Bill 291 was introduced by Senator Peter Miller. This bill raises the pegged levy for the Chicago Municipal Tuberculosis Sanatorium to $5,700,000 from $5,250,000 and at the same time gives all the Municipal Tuberculosis Sanatoria the privilege of hospitalizing patients outside of their own institution.

Senate Bill 290 has been introduced and provides for the appointment of a Tuberculosis Commission to be made up of nine members: three members from the Senate to be appointed by the President protempore of the Illinois State Senate; three members from the House of Representatives; and three members to be appointed by the Governor, with the Director of the Illinois State Health Department as a member ex-officio. This commission is to study the problem of unified tuberculosis control throughout the State of Illinois during the ensuing biennium and make recommendations for the co-ordination and/or additional methods of increasing the efficiency of tuberculosis control and eradication in the State of Illinois. The commission is required to report its findings and recommendations to the 69th General Assembly of the Illinois State Legislature not later than May 1, 1953.

Senate Bill 221, The Public Protection Law (a bill for the hospitalization of recalcitrant patients) has been studied by the committee and has been endorsed by the Council of the Illinois State Medical Society at its February meeting. This bill has passed its first reading and strong support is being mobilized for its passage.

A Teachers Compulsory X-Ray Law will be brought up in the legislature in the near future and it has been approved by this committee in principle, and this endorsement has been concurred in by the Council of the Illinois State Medical Society at its February meeting.

The Tuberculosis Control Committee recommended to the Council of the Illinois State Medical Society at its February meeting that a letter be written to each County Medical Society recommending that a Tuberculosis Committee be appointed and that the names of the committee should be reported to the Secretary of the Illinois State Medical Society. Up to this writing twenty-six counties have reported action on this proposal. It is recommended by the committee that these committees take on active interest in the tuberculosis control program in their local county in order that the County Medical Societies and the Illinois State Medical Society may take more effective action in the early eradication of this disease. The counties that have acted on this proposal are: Adams, Bureau, Carroll, Christian, Clay, Clinton, DuPage, Franklin, Grundy, Kane, Knox, Lake, Lawrence, Livingston, McDonough, McLean, Mercer, Morgan, Peoria, Rock Island, Saline, Warren, Wayne, Will, Williamson, and the Chicago Medical Society.*

The following specific recommendations are made by the committee for consideration by the House of Delegates of the Illinois State Medical Society:

1. The Illinois State Medical Society again endorses the survey method for the control of tuberculosis and recommends the use of this method to all County Medical Societies. It also recommends that follow-up 14x17 films by the survey agency be encouraged in order that the full value of the survey may be obtained.

2. The Illinois State Medical Society recommends that the House of Delegates again go on record as endorsing the policy of routine chest x-rays for all admission to hospitals in the State of Illinois.

3. The Illinois State Medical Society recommends the endorsement of the following legislation: Senate Bills 221, 290, 291 and House Bills 228, 229.

a. The Public Protection Law, Senate Bill 221. (A bill to hospitalize recalcitrant tuberculosis patients.)

b. Senate Bill 290, a bill to establish a Tuberculosis Commission to study the problems of tuberculosis in the State of Illinois for a period of two years and to report the findings and recommendations to the 69th General Assembly of the Illinois State Legislature not later than May 1, 1955.

c. Senate Bill 291, a bill to raise the pegged levy for the Chicago Municipal Tuberculosis Sanatorium to $5,700,000 and to permit the Municipal Tuberculosis Sanatoria to hospitalize patients and pay for such hospitalization in other sanatoria than their own.

d. House Bills 228 and 229. These two bills amend the State Tuberculosis Hospital Act and the State Tuberculosis Subsidy Laws in order to assist the Illinois State Health Department in the efficient administration of these laws.

4. The Illinois State Medical Society wishes to again extend its support and recommends the support by its component County Medical Societies to all the governmental and voluntary agencies who are cooperating to effect the eradication of tuberculosis.

5. The committee recommends that the House of Delegates request that every County Medical Society in the State of Illinois have a tuberculosis committee and that the Secretary of the Illinois State Medical Society should be informed of the members of these committees.

Respectfully submitted, GEORGE C. TURNER, M.D., *Chairman,* DARRELL TRUMPE, M.D., WILLIAM BRYAN, M.D., JAMES HUTTON, M.D., CHARLES PETTER, M.D., BERNARD KLEIN, M.D., *Committee on Tuberculosis Control.*

DR. GEORGE C. TURNER: We have no additional report but we have an announcement. There will be a luncheon on Thursday at 12:30 P.M. in the Chicago Room for all members of the County Tuberculosis Committee. We now have 67 acceptances to invitations to this luncheon. There are a number of tickets left and we would like to have the members of the House of Delegates, particularly those from the counties who do not have representatives come in as guests of the Tuberculosis Institute of Chicago and Cook County, and the Illinois State Tuberculosis Association. The tickets are complimentary and can be picked up at the information desk.

COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

The past year has been one of continued growth for all types of voluntary prepayment health insurance plans. There seems to be little doubt that people generally are becoming increasingly aware of the value and necessity of insurance protection against a portion of the cost of medical, hospital and related health services.

THE ILLINOIS PLAN:

There have been no changes, during the past year, in the list of commercial carriers offering medical and surgical expense policies as approved for participation in The Illinois Plan.

Those carriers are:

1. The Aetna Casualty and Surety Company, 120 So. LaSalle St., Chicago.
2. Illinois Mutual Casualty Company, Peoria.
3. John Hancock Mutual Life Insurance Company, 209 So. LaSalle St., Chicago.
4. Northern Trust Life Insurance Company, Aurora.
5. G. H. Poulsen and Company, 69 W. Washington St., Chicago, representing the Metropolitan Casualty Insurance Company.

As of December 31, 1952, more than 4½ million people in Illinois had some form of surgical or medical and surgical insurance underwritten by insurance companies. Of these, approximately 480,000 held coverage under carriers participating in The Illinois Plan.

BLUE SHIELD:

Seventy-eight Blue Shield Plans are in operation in the United States and Canada. Their aggregate enrollment, which is constantly increasing, now totals more than 23 million persons. Four of the plans are located in Illinois. They are: Illinois Medical Service, Chicago; Medical-Surgical Service of Illinois, Alton; Northern Illinois Medical Service, Rockford; and Rock Island County Medical Service, Moline. Some 835,000 persons are now enrolled in one of these four plans.

Illinois Medical Service, largest of those in Illinois, has approximately 791,000 subscribers in 97 of the state's 102 counties. Nearly $4,600,000 were paid out on behalf of more than 8,500 subscribers.

BLUE CROSS:

Approximately 7 million people in Illinois now carry some kind of hospitalization insurance. Of these, about 2½ million are enrolled in a Blue Cross plan. Of the total population of the United States and Canada, some 87 million people have some form of hospitalization insurance, of which more than 44 million are under Blue Cross.

* * * * *

Health Improvement Associations in Illinois, are continuing their growth, both in numbers and in territory covered. In the very near future, it seems likely that the rural populations of virtually every county in the state will have access to both Blue Cross and Blue Shield through the enrollment facilities of our Health Improvement Associations.

On the national scene, increased interest in voluntary health insurance is clearly evident. With the issue of national compulsory health insurance shelved, at least for the present, medical men, employers, labor representatives and insurance people of all types are giving

more and more attention to ways and means of improving the coverage and reducing the cost of voluntary health insurance. Meanwhile, enrollments in programs of this kind continue to grow at a most gratifying rate.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* WARREN W. FUREY, M.D., EDWIN S. HAMILTON, M.D., JACOB E. REISCH, M.D., DAVID B. FREEMAN, M.D., JOSEPH S. LUNDHOLM, M.D., THOMAS J. KELLY, M.D., *Committee on Voluntary Prepayment Plans for Medical and Surgical Care.*

REPORT OF THE WOMAN'S AUXILIARY

The Woman's Auxiliary to the Illinois State Medical Society celebrates its silver anniversary this year. As behooves a group which comes to its twenty-fifth milestone, this has been a year of taking stock of our assets, of reorganizing, and redirecting our forces.

There are now Auxiliaries to County Societies in thirty-eight counties with Cook County having eleven branches and St. Clair two. In addition we have fifty members-at-large, making active representation in twenty-five other counties. Despite real effort on the part of our councilors, the chairmen, president-elect Mrs. Henry Christiansen, and the help given us by the Councilors of the Illinois State Medical Society no new Auxiliary group has been added during the current year; however, we have a slight increase in membership.

The key to further organizational progress seems to be the *members-at-large.* Through the efforts of their chairman and representative, Mrs. G. H. Edwards, we have kept in close contact with these members. They have received the "Auxiliary News," current legislative material from state and national level, and pertinent material from other standing committees. They were invited to our fall conference and will have a special session and tea at the state convention. By these means, we hope to make these women more informed members who feel they are an active part of the Auxiliary.

The full picture of our progress can best be seen by a resume of the work carried on by the major standing committees.

ARCHIVES: Aside from the routine work of recording our history, the chairman, Mrs. A. J. Sullivan, wrote a history of our twenty-five years. This was published for us by the Illinois State Medical Society and will be an anniversary souvenir of our convention.

BENEVOLENCE. At the 1952 delegate meeting, our dues were increased one dollar, with this dollar earmarked for Benevolence. In addition, almost every Auxiliary has raised money for further contributions to the fund. When the audit is final we expect the total to be about $6,000.00.

Special memorials in Benevolence were set up for deceased past state presidents Mrs. Harry Dooley and Mrs. Solomon Jones. The chairman, Mrs. George W. Koivun designed and the Medical Society printed, cards to be sent to families in whose honor or memory gifts have been made to Benevolence. A suitable acknowledgement card was also printed for the donor. These were distributed to the county groups and will be on display at the convention. We hope many members will find the use of these Benevolence cards an easy and gracious way in which to express their sympathy in times of trouble or their congratulations in times of joy. When contributions are made they will be sent directly to our state treasurer (except in Cook County where checks will go directly to the Cook County Benevolence Chairman). She will send an announcement card, omitting any mention of the sum, to the recipient family and an acknowledgement card to the donor.

THE BULLETIN: is the official magazine of the Woman's Auxiliary to the A. M. A. State Chairman of Subscriptions, Mrs. John T. Boswell, reports we have about the same number as in the preceding year.

CONVENTION gives us an opportunity to introduce ourselves to the doctor's wife who is not yet a member, to rebuild enthusiasm, inform the active member, review the work of the past year, and plan for the future. The chairman, Mrs. Nicholas G. Chester, has worked in close cooperation with me, the doctor advisory committee, Mrs. Frances Zimmer, and the officers of the State Medical Society. We have reorganized the plan of the meeting to lay special emphasis on informing members and planning for the future. Changes initiated this year are: (1) Formation of three reference committees to handle all reports. These committees will meet consecutively so that any person may attend all hearings if they wish. (2) Establishment of separate group meetings for county chairmen of each of the standing committees. These meetings will be presided over by the state chairman, will present a qualified speaker, and give an opportunity for the present and newly named chairman to discuss problems and plan for the coming year. (3) A preconvention meeting of county presidents and presidents-elect. County reports will be given here and problems freely discussed. (4) A speaker will be presented at each of the two delegate sessions.

We are grateful to the State Medical Society for adjusting their schedule so that the Auxiliary can once more meet in the same hotel with the doctors, and for giving us the opportunity to be hostesses to them at our Silver Anniversary Fete.

FINANCE chairman, Mrs. Lewis T. Gregory, and her committee have budgeted carefully. Auxiliary dues are three dollars. Of this one dollar per member goes to the National Auxiliary for dues, one dollar to Benevolence, and the other dollar must be stretched to cover the current expences of the State Auxiliary. By watchful planning we have succeeded in operating on this amount. The State Medical Society has assisted us by (1) A gift of six hundred dollars for entertainment at State Convention. (2) Supplying stationery. (3) Doing most of our printing and a small part of the mimeographing. (4) Giving us a page in the monthly

issue of "Illinois Medical Journal." (5) Giving us a space in the doctors' convention "flyer." (6) Paying printing and distribution costs on our "Auxiliary News." This last item is our budget headache. We have not been able to find a commercial sponsor. If the State Society feels it is an expense they should not continue to assume for us, I believe we will need to be realistic and increase dues to cover that cost. This is a decision to be faced during the next year.

"Auxiliary News," edited by Mrs. Carl Sibilsky, is printed four times a year. We feel "the News" has brought us into closer contact with our members and that it is an excellent organ through which to distribute informative and enthusiasm-building material. We have been careful to include legislative news and have worked with Mr. John W. Neal at state level. I cannot fail to express the wish that our "Auxiliary News" could be mailed to the wife of every doctor in Illinois—regardless of whether or not she be an Auxiliary member. I believe it would be a fine Public Relations gesture, would win new members for the Auxiliary, and would be an easy medium through which information could be sent to the non-member. She too goes to church, the P. T. A., and the bridge club, and can quietly speak for American medicine if she knows their stand. At present we have no contact with her for state and national mailing lists by-pass her. I sincerely hope that when we secure a permanent sponsor (be it commercial or the State Medical Society) serious consideration will be given to this idea.

Legislation. Mrs. Walter Shriner, chairman, directed us in an active "get out the vote" campaign. County groups have been urged to devote some time at each meeting for a discussion of material released in the A. M. A. Washington News Letter and for a resume of medical legislation pending in the state. State and national legislators have been contacted by members as requested.

Program suggestions made by Chairman, Mrs. A. T. Kwedar, emphasized knowing the good job American Medicine is doing and the available health facilities in our communities. Miss Ann Fox of the Illinois Education Committee was most helpful in supplying speakers for a number of groups.

Public Relations work has keynoted this year and Mrs. Edward G. Warnick, chairman, has instigated excellent work at county level. (1) Many counties held laity meetings and presented well qualified speakers to their community groups. We are grateful to P. R. director Mr. James Leary for his suggestions of good topics (printed in the "Auxiliary News") and for obtaining speakers for such occasions. (2) Members were urged to do something for their communities, and I am happy to say that our work record in Civil Defense, Red Cross, Cancer Society, Heart Association, Children's groups, and so forth, is admirable. (3) Members were urged to assist in nurse recruitment programs where needed. (4) Mrs. Edwin S. Hamilton was appointed special nurse recruitment chairman and through her contact with the "Joint Committee for Nurse Recruitment in Illinois" we hope to better fit the Auxiliary's efforts into the general plan and avoid duplications in work. (5) Several counties published telephone directories of available health facilities in their community. This listing, printed on a small card suitable for hanging by the phone, gave the numbers of such places as: American Cancer Society Information Center, Blood Bank, Coroner's Office, Diagnostic Tumor Clinic, Doctors' Exchange, Fire Department Rescue Squad, Health Department, Hospitals, Nurses' Exchange, School Nurse, T. B. Association, T. B. Hospital, Visiting Nurse, Well Baby Clinic, and so forth. There was a blank space in which to write the phone number of the doctor of one's choice, and an ambulance number. These directories were distributed from house to house. The card was headed, "Health Services in Blank County" and at the bottom in small type stated, "Compliments: Woman's Auxiliary to the Blank County Medical Society." We considered this a fine public relations effort and in at least one county (Vermilion) the local doctors were so pleased with the project that they assumed the cost of printing ten thousand of these directory cards. (6) More than half of the county groups maintain student nurse loan funds. (7) Several counties have shown films aimed at nurse recruitment, to mother's clubs and High School groups. (8) We helped staff Fair booths for Cancer, Heart, Polio, and other allied medical groups. (9) We have asked each Auxiliary to have at least one program by way of self-examination. Skits were outlined and proposed such as "The Doctor's Wife Answers the Telephone" and "The Doctor's Wife at the Bridge Table." (10) The president attended the Chicago Public Relations session in the fall and the one day P. R. meeting preceding the Interim Session of the A. M. A. in Denver. With the hope of strengthening the knowledge of our leaders we plan to send both our president and president-elect to these two meetings next year.

Revisions were handled by Mrs. Warren W. Young. We now have voted the changes in our constitution deemed necessary prior to a reprinting. The State Medical Society has already agreed to do this printing.

Today's Health. Mrs. Gregory Carey has been a diligent chairman. Since this report must be made before the "Today's Health" contest closes no accurate figures can be given. However, I believe we will have about the same number of subscriptions as last year and it seems probable that we may have a county prize winner in one group.

Press and Publicity has been under the direction of three members: Mrs. Charles H. Lesage, Mrs. John H. Glynn, and Mrs. G. T. Buttice. The publicity has been generous and on the whole good.

Civil Defense has been studied. Participation in existing local set-ups has been urged by the chairman, Mrs. L. N. Hamm. Several groups have shown Civil Defense movies in their areas.

There were four Board meetings during the year,

three in Chicago and one in Danville. Mrs. H. C. Hesseltine and Mrs. Holland Williamson served as hostesses for these sessions. We were pleased to have Dr. Warner Newcomb and Dr. H. C. Hesseltine present at two Board meetings. Three speakers were presented at Board. Mr. John Neal spoke on "The Doctor, His Wife, and Political Activity," Dr. Percy Hopkins' topic was "Illinois Medical Service," and Dr. Maurice M. Hoeltgen talked on "Alleviating the Nurse Shortage." We are grateful to Blue Cross-Blue Shield for being hosts to our March Board meeting and luncheon.

There were three other standing committee chairmen: Mrs. S. G. Plice, chairman of credentials and registration, Mrs. H. E. Snow in charge of printing distribution, and Mrs. J. M. McDonough, reference chairman. They carried out their duties efficiently and promptly.

Like the Medical Society, the Auxiliary has eleven councilor districts. The Councilors for this year were: First District—Mrs. J. S. Lundholm; Second District—Mrs. R. E. Davies; Third District—Mrs. Paul C. Bucy, Mrs. Cyril L. Hale, Mrs. Carlo Scuderi; Fourth District—Mrs. William Johnson; Fifth District—Mrs. Henry Berchtold; Sixth District—Mrs. Carl Hagler; Seventh District—Mrs. Charles Downing; Eighth District—Mrs. A. R. Brandenberger; Ninth District—Mrs. Douglas Lehman; Tenth District—Mrs. R. B. Ellis; and Eleventh District—Mrs. E. S. Leimbacher. These Councilors arranged for meetings of each county with the president or some state officer as the speaker and accompanied the president on the visit. They made efforts to organize those areas without an Auxiliary and served as a link between the existing county groups and the State Board.

The Auxiliary has no paid employees so the job done by the treasurer, Mrs. S. M. Hubbard, the corresponding secretary Mrs. W. T. Shaffer, and the recording secretary Mrs. R. E. Dunlevy, are deserving of special mention and praise. A great burden of responsibility lies on these three officers and their work was carried on with an admirable degree of perfection.

Our *doctor advisory committee* is Dr. Warner H. Newcomb, Dr. C. Paul White, Dr. H. Close Hesseltine, Dr. Harold M. Camp, and Dr. H. Kenneth Scatliff, chairman. This committee was consulted on every matter of policy prior to its presentation to the Auxiliary Board. They also checked our budget. Our directors and officers met with our advisors in Chicago early in the fall, to talk over questions and plan for the year ahead. I feel deeply indebted to this group of men and most especially to the chairman, Dr. H. Kenneth Scatliff. No question from us was left unanswered. If the advisors were in disagreement, Dr. Scatliff presented the matter to the Medical Society Council for decision.

The Auxiliary is making progress. We are at work. Our members have been willing to accept responsibility. They have been cooperative in our new undertakings. Over all there has been amity. We thank our predecessors for the foundation they have given the Auxiliary and our wish on this twenty-fifth anniversary is that we can grow in numbers, in usefulness to the medical profession, and in friendship among ourselves.

Respectfully submitted, MRS. HARLAN ENGLISH, *President, Woman's Auxiliary to The Illinois State Medical Society.*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Your Advisory Committee to the Woman's Auxiliary respectfully commends to your attention the report the Auxiliary has submitted through its President, Mrs. Harlan English, which you will find printed just preceding in this Handbook.

We have carefully followed their work throughout the year and their printed report brings you in summary a brief survey of the widespread activities and interests with which they are engaged. It is the Committee's feeling that these sorts of activities, outside the scope of scientific medicine itself and yet intimately aligned with medical thinking, provides the most effective and beneficial public relations arm of the profession.

Each delegate might well take home to his individual county society the thought that *each* county society could well benefit by the establishment of a component part of this Auxiliary if not already formally organized. The Auxiliary is endeavoring to reach this unorganized group by a membership-at-large device and this while speaking well for the Auxiliary as a whole, does not directly benefit the profession at a local level.

One of the problems to which your Committee desires to direct attention concerns their publication, "Auxiliary News." The Auxiliary has found this a most useful medium to inform each doctor's wife about the aims, the objectives and the plans of the State Society. Not being able to publish this small news sheet out of their slender treasury, the Council of the Society has authorized the expense of the same, pending an arrangement whereby a sponsor might be found who would help out with this project. They have conscientiously tried to bring this about but have been unable to do so and they are, in consequence, quite concerned. Are they to be allowed to continue this method of communication? Will they have to increase their dues to cover the expense? Or will they have to take a step backward and abandon its publication? These are all questions with which they have struggled.

The Council has been most generous in their help and viewpoint concerning this activity of the Auxiliary, but it would seem that any more definitive steps looking to a more permanent arrangement on behalf of the Auxiliary is entirely the prerogative of the House of Delegates.

Respectfully submitted, H. KENNETH SCATLIFF, M.D., *Chairman,* WARNER A. NEWCOMB, M.D., C. PAUL WHITE, M.D., H. CLOSE HESSELTINE, MD., HAROLD M. CAMP, M.D., *Advisory Committee to Woman's Auxiliary.*

COMMITTEE ON DIABETES

There has been no formal meeting of the Committee on Diabetes due to the absence of problems demanding immediate decisions. It does seem desirable to outline the Committee's concept of the Society's responsibility to the diabetic patient and to the community.

Diabetes is a metabolic disease, the management of which presents in various individuals, not only problems induced by the severity of the defect, but others of emotional and mental origin associated with the acceptance of a regimen of living and treatment which must be continued throughout life. These problems fall within the scope and responsibility of the physician who accepts the patient for treatment. Since the management of a diabetic patient involves the application of so many meticulous details and the advances in this field are coming so rapidly, it is recommended that the Educational Committee or the Committee on Postgraduate Education provide in their programs statewide coverage on this subject, and that the Chairman of the Medical Section include one paper on diabetes at the Annual Meeting of this Society.

The Society is also interested in the effects of diabetes on the physical, economic, and social health of the people of Illinois as a whole. This poses the question as to how the Society, composed of a group of doctors, can assist in the attainment of these objectives for the citizens of Illinois, a group of their neighbors. This obviously will have to be accomplished by an educational program sponsored by the Society and directed towards the People. It would seem that such a program should have four objectives:

1) The Detection of Unknown Cases of Diabetes.

Diabetes is a hereditary disease, in which the disorder is latent at birth but becomes manifest at some later date due to unknown factors. Present methods of treatment are prolonging the lives of diabetics with their subsequent marriage and reproduction of diabetic children, or children with a recessive diabetic gene. One can see that a sizeable number of unknown diabetics could exist in a community until acute episodes of illness reveal the diagnoses in individual members of this group.

Early adequate treatment of diabetes ameliorates the disease and protects the pancreas from deterioration. The American Diabetes Association sponsors a detection drive of short duration once a year, to which the County Societies have given variable support. Much better results could be accomplished through a program which is continuously operating in the field of potential diabetics. The diabetic could be encouraged to become a missionary in examining the urines of all his relatives, near and distant. Under the leadership of the doctors of the community, the efforts of the diabetics could be pooled and a detection center, operative throughout the year, could be set up at a local hospital. The diabetics could then concentrate their energies on persuading individuals to go to the center for examinations.

2) The community should be taught that diabetics can become good and dependable employees, that their absentee record need not be high, and that there should be no contra-indication to their employment other than insurance regulations covering sick leaves and retirement allowances.

3) The community should be taught that diabetics are acceptable for life insurance (under special contracts) providing they cooperate with their doctor in his management, see him at regular intervals, and thus establish a performance record. This record can then be presented as a part of the insurance application. Without such a performance record his application will receive very little consideration.

4) The community should be taught that the marriage of a diabetic and a non-diabetic individual does not necessarily mean that the children of this marriage will be diabetic, but it does mean that they will carry a recessive gene for diabetes. Now if these children are married to others with recessive genes, then some of their progeny will have diabetes.

Respectfully submitted, ROBERT W. KEETON, M.D., *Chairman,* T. D. MASTERS, M.D., GEORGE M. PARKER, M.D., WILLARD O. THOMPSON, M.D., *Committee on Diabetes.*

COMMITTEE TO INVESTIGATE THE CORONER'S OFFICE

For years, many physicians and medical organizations have been keenly aware of the serious inadequacies of the Coroner System in the State of Illinois which has remained essentially unchanged since 1874. Although the recent trend in other States has been toward the more modern and more efficient Medical Examiner System for the scientific investigation of deaths from unnatural causes, a change in this direction in Illinois has not seemed feasible because the elective office of County Coroner was established by the Constitution of 1870. Change through Constitutional Amendment is a difficult procedure.

The resolution affirming a desire to find some way to change the archaic Coroner System to a Medical Examiner System in the State of Illinois was Adopted by the House of Delegates of the Illinois State Medical Society on May 13, 1952. Pursuant to the resolution, a Committee on Revision of the Coroner's System was appointed by F. Lee Stone, M.D., Chairman of the Council.

The first meeting of the Committee was held at the Sherman Hotel on Saturday, August 23, 1952. The Committee concluded that an attempt to obtain revision of the Coroner System through Constitutional Amendment would be too difficult; but that revision through definition of the Coroner's Act could be done through direct legislation. This has been the approach Through Doctor White, contact was made with Mr. Thomas J. Welch, president of the Illinois Bar Association and he was informed of the purposes of the Committee from the Illinois State Medical Society. At present a tentative bill, which in effect, supplants the Coroner System by the Medical Examiner System has been prepared and submitted to the Illinois Bar Association

through their president, Thomas J. Welch. A committee of this group is expected to meet with the Committee of the Illinois State Medical Society to finally frame this bill and present it to the present session of the Illinois State Legislature. If this instrument can become a law, a great advance in medico-legal practice in the State of Illinois will have been accomplished.

Respectfully submitted, EDWIN F. HIRSCH, M.D., *Chairman,* HARLAN ENGLISH, M.D., SAMUEL A. LEVINSON, M.D., C. PAUL WHITE, M.D., F. LEE STONE, M.D., *Ex-Officio,* JOHN W. NEAL, *Legal Adviser, Committee to Investigate the Coroner's Office.*

INTERPROFESSIONAL RELATIONS COMMITTEE

The following is a brief report on the activities of the Interprofessional Relations Committee for the past year.

The activities of the Interprofessional Relations Committee have been largely relegated to and integrated with the activities of the Illinois State Interprofessional Council. This Council was formed as a result of activities instigated by the Interprofessional Relations Committee of the Illinois State Medical Society and its members. The Interprofessional Relations Council was formed to work out problems that are common to all professions operating under the Illinois Medical Practice Act.

In the past year there have been regular meetings in which the members of the Interprofessional Relations Committee of the Illinois State Medical Society have met as members of the Illinois Interprofessional Council. Members present at these meetings represent the Illinois State Dental Society, Illinois State Pharmaceutical Association, Illinois State Veterinary Medical Association, State Optometric Society, and Illinois State Medical Society. This committee now functions as a source of information for all of the allied professions of the healing arts and they also function as a forum to bring problems that are confronting the various specialities as they relate to one another. Much progress has been made in establishing a uniform approach to these joint problems. Much enthusiasm has been shown for the development of the local Interprofessional Council on a local level and to work in harmony with the State Interprofessional Council, this last body functioning in an advisory capacity.

Several letters have been received from organizations outside of the state relative to obtaining information for setting up organizations in their localities similar to the Illinois State Interprofessional Council. Since the function of this Council and the Interprofessional Relations Committee activities dovetail the part played by the State Medical Society it has been in part the activities of the Chairman of the Interprofessional Relations Committee. The states of California, Georgia and Wisconsin have considerable ground work laid out at the present time to fulfill their plans following the program as described in the Constitution of the Illinois Interprofessional Council. Concrete efforts were expended to voice expression relative to legislation pending in the Illinois State Assembly relative to the healing arts. Meetings with the Governor by a joint group from the Interprofessional Council representing members of the Interprofessional Relations Committees, had a very definite impact upon the Governor.

Efforts are also being made to preserve the intent of the existing laws by not favoring legislation to recognize the Illinois Osteopathic Hospital, The Illinois Osteopathic School of Medicine, and the licensing of Osteopaths for the unlimited privileges for which they ask. Activities to present the healing arts viewpoint has been appropriately expressed to the members of the Assembly.

Changes in the sales tax laws are also of a profound interest to the Interprofessional Council. These and many other things constitute the basic activities that the Interprofessional Council has been active in the past year. The laws that are being considered could make all the professional people sales tax collectors together with all the added physical effort pending such added burdens.

There has been an increasingly large number of men from all professions attending the meetings in Chicago. In this way it has been possible to acquaint more and more the men of the other professional with a scope of our present and future activities. The Illinois and National Association of Chiropractors are interested in becoming active members of the Interprofessional Council.

Respectfully submitted, WAYNE B. SLAUGHTER, M. D., *Chairman,* F. M. HAGANS, M. D., FRED H. MULLER, M. D., HARRY M. HEDGE, M. D., ELLIOTT P. BURT, M. D., *Interprofessional Relations Committee.*

COMMITTEE ON CARDIOVASCULAR DISEASE

The Committee on Cardiovascular Disease of the Illinois State Medical Society met July 27, 1952, at the Sherman Hotel, Chicago, Illinois. Dr. Katz, Dr. De Takats of Chicago, Dr. Walsh of Peoria and Dr. Pearce of Quincy were in attendance.

The purpose of this Committee is to act as a liaison between the Chicago Heart Association, Illinois Heart Association, and the Illinois State Medical Society. This Committee is to inform the Illinois State Medical Society about the activities of all organizations carrying out educational programs for lay and professional education groups, which involves not only political but scientific matters.

Numerous recommendations were made at this meeting in July. Data has been collected as to the amount of money available for cardiovascular control allocated by the Federal, State and Local Government and non-official agencies, throughout the State. The money allocated by official agencies has been used for the most part in Chicago, Herrin and Springfield. Although educational material has been used by the State Department of Health through the Illinois Heart Association and a wider distribution throughout the state.

Aid has been given to Rehabilitation of cardiovascular patients through support of the amendment to the Workman's Compensation Law, which would permit those handicapped in obtaining employment.

A section on cardiovascular disease, although semi-official, has been established for the annual meeting of the Illinois State Medical Society. Dr. Walsh of Peoria is the chairman, Dr. Wright Adams, secretary, of this section.

A second meeting was held November 30th, 1952, at the Sherman Hotel. Dr. Louis N. Katz, Dr. Wright Adams of Chicago, Dr. James Walsh of Peoria and Dr. Warren Pearce of Quincy attended this meeting.

Representatives from the Chicago Health Department and the Illinois Health Department met with this Committee. Dr. Gowen agreed to finance and distribute the Heart Bulletin to Physicians in various societies in down state of Illinois as a trial. This Committee will continue to function and hopes to further the Professional Education and cooperate with cardiovascular Disease Control.

Respectfully submitted, WARNER H. NEWCOMB, M.D., *Chairman,* WRIGHT ADAMS, M.D., WARREN PEARCE, M.D., JAMES A. WALSH, M.D., LOUIS N. KATZ, M.D., GEZA DE TAKATS, M.D., *Committee on Cardiovascular Disease.*

FIFTY YEAR CLUB COMMITTEE

The Fifty Year Club of the Illinois State Medical Society was organized 15 years ago. This was the first organization of its kind in the United States. Since then quite a number of the states have followed suit, and organized similar clubs. Any physician who has practiced 50 years, and has been recommended by his local society or the officers of the society in whose jurisdiction he resides is eligible. No dues are exacted.

Since its organization more than 850 physicians have been inducted into this club. At the present time, we have more than 400 members, located as follows:

Chicago	182
Downstate	245
Total	427

While more than half of the physicians in the State of Illinois reside in Chicago they furnish only about 40% of the members of this club, while downstate furnishes 60%. Do the physicians in downstate live longer by reason of their quiet environment or do we have better physicians downstate than we have in Chicago?

Each year an invitation is sent to every member of the Club inviting them to attend a complimentary luncheon given by the Illinois State Medical Society. This usually brings together 85-90 old physicians accompanied by 15 or 20 of their ladies. They renew old friendships, and swap stories concerning their early practice and their old school days. Quite a number of our members live in distant states, but return for these get-together luncheons which are hugely enjoyed by all present.

Of the 5 physicians who have received the award of being the outstanding general practitioner of Illinois, four have been members of the Fifty Year Club. The organization of this club and these get-together luncheons have been the means of bringing many of the older doctors to our state meetings who would otherwise not attend.

Respectfully submitted, ANDY HALL, M.D., *Chairman,* E. H. OCHSNER, M.D., E. E. DAVIS, M.D., *Fifty Year Club Committee.*

DR. ANDY HALL: This year our Secretary sent me a list of 435 members of the Fifty Year Club, to whom I sent invitations to attend our annual banquet. About two weeks later, ten days ago, he sent me an additional list of 75 who were eligible to receive the Fifty-Year certificate, whose county societies had neglected to call to his attention. I would suggest that in the future the secretary of each county society check over his list and see that we get the names of those eligible to membership in the Fifty Year Club before the annual meeting.

THE SECRETARY: Mr. President, I would like to tell Dr. Hall that most of these names were procured in our office. I have one girl who each year before the annual meeting goes over the entire list and she notifies the secretary of the county society that a certain number of doctors are eligible for the Fifty Year Club. They get the notification from us rather than we getting it from them. If they got it early it would not cause you inconvenience.

THE PRESIDENT: This supplementary report will be referred to Reference Committee A.

REPORT OF THE EDITORS ILLINOIS MEDICAL JOURNAL

When we submitted our annual report last year we stated that the Chicago office of the Society was in the process of being moved from 30 North Michigan Avenue to 185 North Wabash Avenue. The change was made immediately after the Annual Meeting and the new quarters makes for more efficient and pleasant surroundings. Your Editors and Mr. L. E. Malley, our Business Manager for the Journal, appreciate the change.

The Journal room contains three desks and can be closed off from the other rooms in the suite. With this new arrangement there is less confusion than existed in the former offices. We spend at least one day each week together in the Journal quarters discussing matters pertaining to the Journal and methods by which the contents may be improved.

During the past year a number of changes have been made in the format and the Journal contents. The color of the cover is now red and no longer changed with each issue as occurred in the past. We appreciate your comments on this change. At this time we are considering a change in the arrangement of the several departments within the Journal in keeping with the suggestions of the members of the Journal Committee and the Editorial Board. These will be presented to the Council and if approved will be instituted in the near future.

At the request of the Council we have added a new department entitled "Know Your Society," in which we mention the functions of the many Constitutional and Council Committees within the State Society. In this new department, "Know Your Society," we hope to be able to elaborate on the functions of each Committee so that when reference is made to a Speakers Bureau for example, the members will know the type of service that is rendered by this particular group. The work of the Educational Committee, Postgraduate Committee and the many other Committees will be explained in the series of short articles which will appear in succeeding issues of the Journal.

During the past year we have attended the joint meetings of the Journal Committee and Editorial Board where a number of plans for improving the Journal were given careful consideration. The Journal Committee is responsible for the publication of the Journal, changes in format, and likewise approves all advertising contracts. The Editorial Board is concerned primarily with the editorial policies and to act upon papers submitted to them by your Editors. The recommendations of both groups must be approved by the Council before changes are made. The various members of the Journal Committee and the Editorial Board have met several times during the past year and have given generously of their time for the best interests of your official publication.

Mr. L. E. Malley, as Business Manager for the Journal, is responsible for all advertising copy. He orders necessary cuts, arranges the monthly billings to advertisers and receives the remittances for the advertisements. He makes up the dummy for each issue. He makes a monthly report to the Treasurer and all advertising receipts accompany the regular report. The official auditor, Mr. Fred N. Setterdahl, goes over the Journal records each year and his report to the House of Delegates includes the financial condition of the Illinois Medical Journal.

Your Editors welcome suggestions relative to improving the Journal and making it what the membership as a whole desires. Your Editors are preparing a short questionnaire relative to suggestions and criticisms of the Journal. This will be mailed to several hundred members selected at random from the mailing list. This survey should reveal which features are preferred by the majority and those that should be eliminated. These suggestions will be presented to the Journal Committee and thence to the Council for final action.

During the past year your Editors have received many compliments and criticisms relative to the Journal. These have been given serious consideration. We have heard for example that the articles do not appeal to the specialists. This is understandable because the Journal is written for the members of the Illinois State Medical Society who are predominantly general practitioners. Our records show that of the seventy-nine scientific articles that were published during the past twelve months, seventy were written by specialists, the majority from Chicago. Many of these authors are on the faculties of our medical schools and are active in teaching and in research. The conclusions are obvious; these authors are not writing for their own group. They are writing for our membership at large. In all probability these same authors send their more scientific articles to the specialty journals as it should be. By the same token, your Editors have turned down several scientific articles because we felt that they were not suitable for our Journal or of sufficient interest to the members at large.

As stated previously, the contents of the Journal are no better than the material received for publication. We urge all of our members to submit papers for publication and may we suggest that the manuscripts be as short as possible and contain less biographic and historical data. On many occasions we have been forced to return long papers with the request that they be shortened, occasionally fifty per cent or more. Preference is given to articles which are clear, informative and meet some need other than that of the author for publicity.

Respectfully submitted, HAROLD M. CAMP, M.D., THEODORE R. VAN DELLEN, M.D., *Editors, Illinois Medical Journal.*

COMMITTEE ON GAMMA GLOBULIN DISTRIBUTION

On April 8, at the suggestion of Dr. Roland R. Cross, Director of the State Department of Public Health for the State of Illinois, Dr. Leo P. A. Sweeney, as president of the State Medical Society, appointed the Illinois Gamma Globulin Distribution Committee. The personnel is as follows: Dr. John Lester Reichert, Dr. Willis I. Lewis, and Dr. Leo P. A. Sweeney.

A meeting was held on April 25, at which the following were present: Dr. Leonard M. Schuman, Chairman and Howard J. Shaughnessy, Ph.D., representing the State Department, Dr. Lewis and Dr. Sweeney. Dr. Reichert was unable to attend, since he was in Boston at the meeting of the American Academy of Pediatrics.

The following plan was formulated:

(1) Names the State Health Department as the sole responsible agency for the distribution of gamma globulin within the state.

(2) Defines the limitations of use.

(3) Allocates the basic quantity of gamma globulin to each state according to the five year (1947-1951) mean of reported cases of poliomyelitis, and

(4) Provides for the special allocations for mass prophylaxis in communities experiencing severe outbreaks of the disease but contingent upon consultation between State and local health authorities.

The plan has been developed jointly by the Illinois Gamma Globulin Distribution Committee composed of members of both the Illinois State Medical Society and the Illinois Department of Public Health. The plan has been approved by the Society (Council action on April 26) and by the State Department of Public Health.

Gamma globulin distribution to private physicians will be restricted for use only in:

(1) Household contacts up to 30 years of age, living in the same family unit with the clinically diagnosed case.

(2) Pregnant women irrespective of age, having intimate contact with any clinically diagnosed case.

Gamma globulin will be available to private physicians at:

(1) All full time city, county and district health department offices.

(2) Regional offices of the State Health Department.

(3) Bureau of Epidemiology, State Department of Public Health, Springfield, Phone 6611, Extension 167.

Dosage and administration:

(1) The recommended prophylactic dosage of gamma globulin is 0.15 c.c. per pound of body weight.

(2) A simplified table based on age, but predicated upon average weights at the respective ages, may be utilized both for the distribution and administration:

	Per Year
Under 6 months	2.0 c.c.
6 months through 2 years	3.0 c.c.
2 years through 20 years	1.0 c.c.
21 years through 30 years	20.0 c.c.
Pregnant women, any age	20.0 c.c.

The plan outlines the methods of obtaining gamma globulin, the maintenance and replenishment of supplies, the use of the local county medical society in the distribution, the special and emergency use of gamma globulin.

The Committee wishes to point out that the supply of gamma globulin now available has not been titrated against all strains of poliomyelities, and therefore is not of proved value in the prevention of poliomyelitis and consequently it should not be used except for measles and infectious hepatitis.

The Committee further wishes to bring to your attention that all gamma globulin for use in poliomyelitis will be distributed to physicians free of charge and that the charge made by the physician is only for the service of giving the injection. This fact should be brought to the attention of the public.

The plan is subject to revision at any time in accordance with changes in the national restrictions, availability of supply, or experience with the state plan.

Following the action on the part of the Council (April 26) the secretary's office sent letters to each county society secretary strongly urging that a Gamma Globulin Distribution Committee be appointed in each county medical society. The names of the committee personnel should be sent to the State Medical Society office in Monmouth, to the Illinois Department of Public Health in Springfield and where practical, to the local full time health officers.

In the immediate future a brochure outlining the plan will be sent to every physician in Illinois, together with a letter prepared jointly by the Illinois State Medical Society and the State Department of Public Health.

Respectfully submitted, LEO P. A. SWEENEY, *Chairman*, WILLIS I. LEWIS, JOHN LESTER REICHERT.

THE PRESIDENT: This report will be referred to Reference Committee "C". There will be a news release to go out to the newspapers. This is one that Mr. Leary got up and will be read by Dr. John L. Reichert.

BEWARE OF BLACK MARKET GAMMA GLOBULIN, MEDICAL SOCIETY WARNS

Chicago—Warning of a probable black market in gamma globulin was sounded today by the Illinois State Medical Society.

Gamma globulin is the blood fraction recently found useful in minimizing paralysis in victims of poliomyelitis.

The warning came in a report made to the House of Delegates of the Society at its 113th annual meeting today (Tuesday) in the Hotel Sherman, by its recently appointed Committee on Gamma Globulin. The report, read to the House by Dr. Willis I. Lewis of Herrin, pointed out that:

1. All gamma globulin is now distributed free to physicians, whose only charge should be for the service of injecting it. Reports of charges ranging from $20 to $50 per injection are current.

2. Any black market gamma globulin administered would probably be from last year's production, which was intended for use in measles and infectious hepatitis, a liver disease. It is not tested for the presence of the poliomyelitis antibodies and carries absolutely no guarantee of effectiveness against that disease.

Members of the Committee, in addition to Dr. Lewis, are Dr. Leo P. A. Sweeney, President of the Society, and Dr. John L. Reichert of Chicago, Associate Professor of Pediatrics at Northwestern University Medical School.

The report pointed out that all gamma globulin now being manufactured is turned over to the control of the Office of Defense Mobilization for distribution. It is paid for by the National Foundation for Infantile Paralysis and the Red Cross.

It is to be distributed free and only to physicians through health department offices, with Dr. Leonard M. Schuman and Howard J. Shaughnessy of the Illinois Department of Public Health in charge.

Distribution is to be made only on the basis of need, for use in persons certified by their physicians as having been in actual contact with proven cases of poliomyelitis. The restriction is based on the fact that available supplies are not sufficient to permit general distribution.

"The net result," said Dr. Reichert, "is that any one who can get gamma globulin from his physician

or anywhere else without having gone through the established procedure can understand, first, that it is probably no good, and second, that he will have to pay a fantastic price for it. We know that a few unscrupulous persons, some of them physicians, I am sorry to say, are offering it to patients already.

"Hence this warning so that the public may not be deceived."

THE PRESIDENT: This Committee is going to have headaches and we hope you will work with us on this. The distribution is controlled from Washington. The State Department of Public Health is the State Custodian of such distribution and we are an advisory committee to the Department. We hope you will form committees in your counties. The procedure will be out very shortly.

The Secretary has some announcements.

THE SECRETARY: We have had a very interesting letter from the Student American Medical Association, which I shall read. It is addressed to the President, Dr. Leo P. A. Sweeney:

Dear Doctor Sweeney:

On behalf of the Student American Medical Association and its five chapters in Illinois, I wish the Illinois State Medical Society great success on the occasion of its One Hundred and Thirteenth Annual Meeting.

Additionally, our Association would like to extend a most cordial and sincere invitation to the members of the Illinois State Medical Society to visit them at their Annual Meeting this June 15, 16 and 17 at the Edgewater Beach Hotel, Chicago. For the first time our Association will have a Technical Exhibit and the program includes panels on "General Practice as a Specialty" and the "Doctor Draft" and is high lighted by the scientific presentation of the "Michigan Mechanical Heart" by Dr. F. D. Dodrill, at 10:45 A.M., Wednesday, June 17.

Your A. M. A. membership card will be sufficient for registration at our meeting, and we sincerely hope that many of your members will be able to drop in and observe our organization at its Third Annual Convention.

Sincerely,
DAVID J. BUCHANAN, President
Student A. M. A.

I have another letter that should be acted upon. The A. M. A. selects its meeting place for three years in advance at the meeting in New York City June 1 to 5. We have a request from the Chicago Medical Society that this House of Delegates join with the Chicago Medical Society and the Chicago Convention Bureau and request that the 1956 annual meeting of the American Medical Association be held in Chicago. I think, Mr. President, some action should be taken.

DR. C. PAUL WHITE, Kewanee: I so move. (Motion seconded by Dr. W. E. Kittler, Rochelle and carried).

THE PRESIDENT: As there is no unfinished business, we will pass to new business and the first item will be the introduction of resolutions.

DR. W. H. NEWCOMB, Jacksonville: I am representing Dr. Garm Norbury in presenting this resolution from Morgan County.

1. *Opposition to Reduction in Medical Services by the Illinois Public Aid Commission at the Expense of the Physician ONLY.*

It is understood that the State of Illinois has contracted to give medical care to certain groups of low-income persons through the agency of the Illinois Public Aid Commission. It would seem probable that such medical service is daily being extended to more and more people.

We have been informed that sufficient funds are not now available for ordinary medical care. In order to meet this difficulty, the Illinois Public Aid Commission has reduced the number of visits by the physician for which it will pay. The Commission, however, points out that it in no way limits the kind or amount of services which may be furnished to recipients by their physicians. These problems are not peculiar to this biennium; they are inherent in all such programs.

We have also been informed that the Public Aid Commission will not pay for hospitalization of a patient unless the patient's physician secures prior approval of the county Public Aid Commission and county Medical Advisory Committee, unless the case is an emergency. The physician must submit a diagnosis, the specific reason for hospitalization, and must state why hospital care rather than any other type of care is required.

We feel that this is a distinct encroachment by the government into the personal relationship of physician and patient.

As everyone here knows, even in the past, physicians have provided more service to recipients of I.P.A.C. than they were paid for. We reiterate that we always have and always will provide care for those who need it, regardless of financial status.

However, since the state has assumed the obligation of providing adequate medical care to certain groups of people, it should find the means to finance it. If the state reduces the grants for such expenditures, it should furnish clear and direct information to its welfare recipients that the medical profession provides services beyond these allowances, and *not* the state.

This committee makes the following recommendations:

1. That the Morgan County Medical Society go on record as opposing any reduction in medical services at the expense of the physician *ONLY*.

2. That the Morgan County Medical Society go on record as opposing any scheme, no matter how worded, in which the hospitalization of a patient deemed necessary by a physician is contingent upon prior review and approval by a lay agency or a fellow physician.

3. That the Morgan County Medical Society au-

thorize the county medical advisory committee to grant blanket approval to any member of the Morgan County Medical Society for the hospitalization of any client of the Illinois Public Aid Commission.

4. That the Morgan County Medical Society inform the heads of the Illinois Public Aid Commission and the State Medical Advisory Committee of these decisions.

This committee wishes to point out that it always has had complete cooperation in all matters from Mr. Deatherage and other members of the local office of the Illinois Public Aid Commission.

THE PRESIDENT: This will be referred to Reference Committee "B".

DR. NEWCOMB: I have a second resolution from Morgan County.

2. *Elaboration of the Principles of Medical Ethics*

Whereas, the Principles of Medical Ethics of the American Medical Association and the interpretations thereof have, as a result of recent rather widely publicized, diversified expressions of opinion, been the subject of much discussion among various individuals and many groups within organized medicine, and

Whereas, the resultant differences of opinion have caused considerable unrest and some misgivings within the medical profession, due primarily to the implications of improper conduct on the part of the profession as a whole because of the improper acts of a small minority of members of the profession; and

Whereas, a number of members of the profession claim as proper the issuance of an itemized joint bill, when more than one physician participates actively in the care of a patient, because of local acceptance of the procedure, by both the public and members of the profession; and

Whereas, the Principles of Medical Ethics of the American Medical Association, while very explicit in consideration of Duties of Physicians in Consultations, and in many other matters of physician relations with one another, do not give sufficient consideration to the duties of physicians in the joint care of a patient;

Therefore be it resolved, that the House of Delegates request the Judicial Council of the American Medical Association to give further consideration to the interpretations of the Principles of Medical Ethics with special reference to proper billing procedures;

And be it further resolved, that the Committee on Constitution and By-Laws of the American Medical Association, at present engaged in a revision of the Principles of Medical Ethics, be requested to give consideration to the drawing up of an amendment dealing with the duties of physicians in instances of active, cooperative care of a patient by two ore more physicians, definite proper conduct and responsibilities of the physicians involved in such care, and stating procedures to be followed in properly billing the patients for services rendered to enable the physician participating in such a case to obtain adequate conmpensation.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business of which Dr. Percy E. Hopkins is Chairman.

DR. W. E. KITTLER, Rochelle: I wish to present a resolution from the Ogle County Medical Society.

3. *Concerning Charges Made by Dr. Paul R. Hawley, Director of the American College of Surgeons, in the May, 1953 Readers Digest.*

In reply to charges made by Dr. Paul R. Hawley, Director of the American College of Surgeons in May, 1953 Readers Digest, I feel the following remarks are indicated.

How can Dr. Hawley, or any other surgeon, always determine when or for what an operation should be performed? One cannot always wait for a pathologist's report.

It is far better to remove an appendix on general suspicion, when nearly all symptoms point toward appendicitis instead of waiting for fatal results, or any other operative procedures after careful consultations, for positive diagnoses are not always possible.

There are good surgeons who do not belong to the College of Surgeons or are diplomates of the American Board of Surgery who do good surgery.

After graduation from recognized medical colleges or universities, then successfully passing State Medical Board examinations and granted a license to practice medicine and surgery, it surely is not ethical and complimentary for an unethical write-up like Dr. Hawley's.

Some members of the College of Surgeons do not hesitate to practice general medicine or take and hold on to the general practitioner's patients. There are many general practitioners, in the rural districts, who are good surgeons and ethical in their practice who must do some surgery in emergencies.

By what right does Dr. Paul R. Hawley assume to be censor or judge of the profession and put himself up as a model of ethics after dragging uncalled for publicity of this kind in a lay magazine, with very little truth to the charges and very libelous to the medical profession? To say the least, Dr. Hawley owes the medical profession a profound apology and should be requested to do so. The term "kick them out of the College of Surgeons" certainly is not complimentary or ethical for such a highly educated and honored profession.

Be it resolved, that this resolution be referred to the American Medical Association and they be requested to ask Dr. Hawley for an explanation of his actions.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

DR. P. B. BLODGETT, Chicago Heights: I have four resolutions to present.

4. *In Support of the Proposed 23rd Amendment*

Whereas, Congressman Ralph W. Gwinn on January 13, 1953, introduced H. J. Res. 123 which would initiate an amendment to the Constitution relative to prohibiting the United States government from engaging in

any business, professional, commercial, financial, or industrial enterprize except as specified in the Constitution, (referred to as the "Proposed 24th Amendment").

Therefore be it resolved, that the Delegates of the Illinois State Medical Society in regular session assembled do hereby express their full support of H. J. Res. 123 and urge the Congress of the United States to pass H. J. Res. 123.

Be it further resolved, that a copy of this resolution be spread upon the minutes of this meeting and that copies be sent to (1) the President of the United States, (2) all members of Congress, and (3) the American Medical Association.

5. *Social Security Program.*

Whereas, there is a growing sentiment throughout the nation that the present Social Security program is basically wrong and should be repealed or revised, and

Whereas, some of its principal faults are:

A. It destroys ambition of the individual and encourages governmental paternalism.

B. It withholds benefits from those reaching the eligible age of 65, unless the beneficiary limits his earned income to not more than $75.00 per month.

C. As more and more old folks become eligible for Social Security benefits, the government will be forced to tax again to meet its Social Security obligations because the taxes collected to finance the benefits have been spent for other purposes and the so-called Social Security Trust Fund holds mostly government I.O.U.'s.

D. According to reliable economists, present Social Security is actuarially unsound; is not insurance but is a scheme for extracting additional taxes.

E. The impractical, costly work-records system requires the services of an estimated 10,000 government employees at an enormous expense to the tax-payers.

F. It tends by usurping the functions of private insurance companies and destroying the incentive for personal private savings to rapidly dry up the principal sources of private risk capital,

and

Whereas, Social Security is the chief activity of the Department of Health, Education and Welfare and far overshadows the importance of the Department's other services of health and education, and

Whereas, according to the investigations by the Harness Subcommittee in 1947 there is evidence of FSA employees breaking the federal law against lobbying by federal employees, and

Whereas, proposals are now pending in the Congress to extend Social Security to additional citizens before the many faults in the present law have been corrected or wiped out, and

Whereas, Representative Reed, Chairman of the House Ways and Means Committee, has appointed a Subcommittee on Social Security, headed by Representative Carl T. Curtis, to make a critical study and thorough investigation of Social Security, and

Whereas, this study offers the potentiality of achieving needed changes in the Social Security Act.

Therefore be it resolved, that the Delegates of the Illinois State Medical Society in regular session assembled make the following recommendation to the President and the Congress of the United States:

1. That Social Security be held at status quo and not extended to any other groups at least until after Representative Curtis' Subcommittee and any other Congressional Committees have completed their studies and adequate time has been allowed for the consideration and proper evaluation of Committee reports by the people.

Be it further resolved, that the Delegates make the following recommendations to Representatives Reed and Curtis, the members of the Subcommittee on Social Security and to the President and the Congress of the United States:

1. That serious consideration be given to having the federal government abandon Social Security by
 A. Having the individual states finance and administer state pensions, if their citizens so desire.
 B. Paying off present beneficiaries with federal funds, or
 C. Transferring the risk to legitimate insurance companies.
2. In lieu of the much preferred abandonment of Social Security (recommendation number one), place Social Security on a pay-as-you-go basic amount pension for everyone at age 65 which would eliminate payroll record keeping; would reduce the number of Social Security employees by 10,000, and would encourage beneficiaries to continue working and contributing to productivity, rather than being forced to depend on government paternalism, as is now the case.
3. Return all old age and assistance welfare programs to the states where they can be administered more humanly, efficiently, and economically.
4. Reduce federal taxes in the amount necessary for the states to finance the assistance programs so that the individual states will have untouched sources for taxation.
5. Remove compulsion from the pay-as-you-go basic amount pension and place the pension system on an entirely voluntary basis in keeping with the principles of the American free market economy.

Be it further resolved, that a copy of this resolution be spread upon the minutes of this meeting and that copies of it be sent to (1) the President of the United States, (2) all members of Congress and (3) the American Medical Association.

6. *Report of the President's Commission on the Health Needs of the Nation.*

Whereas, the Truman Commission on the Health Needs of the Nation on December 18, 1952 released Volume V. of its Report which covered the Commission's recommendations, and

Whereas, virtually every one of its recommendations, with regard to medical and hospital care and health needs generally, would, in the final analysis, shift initiative, authority and responsibility from the individual, from the community and from the state to the federal government, and

Whereas, the implementation of the Commission's recommendations would lead to further socialization of medical care through federal control, and

Whereas, the Commission proposes grants and subsidies of an additional two billion dollars to be added to the present confiscatory tax bill of the American people, and

Whereas, virtually all of the Commission's recommendations can be carried out more efficiently and economically at the local level of individual and community responsibility, and

Whereas, individual and community responsibility for health afford the best means of providing the people with quality medical care, and

Whereas, virtually all of the Commission's recommendations are contrary to a basic principle of limitation of central authority for self-governing people.

Therefore, be it resolved, that we, the Delegates of the Illinois State Medical Society in regular session assembled condemn the recommendations of the Truman Commission on the Health Needs of the Nation because they are slanted towards a socialized economy and the antithesis of the principles of indivdual liberty and Freedom.

Be it further resolved, that a copy of this resolution be incorporated in the minutes of this meeting and that copies be sent to (1) the President of the United States, (2) all members of Congress, and (3) the American Medical Association.

7. *Resolution on the International Labor Organization.*

Whereas, the International Labor Organization, meeting in Geneva in June, 1952, has approved a Convention (treaty) on minimum standards of social security in nine fields — medical care, sickness benefits, unemployment benefits, old-age benefits, unemployment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits, and

Whereas, ratification of this Convention by the United States Senate would place this country under obligation to put at least four of the nine programs in operation, and

Whereas, ratification of the Convention by the United States Senate would be a step toward plunging this nation further into nation-destroying Socialism, and

Whereas, the United States Congress in 1935 voted this country a member state of the International Labor Organization without public hearings or debate.

Therefore, be it resolved, that the members of the Illinois State Medical Society recommend and urge the Senate of the United States not to ratify this Convention and to withdraw this country from membership in the International Labor Organization.

Be it further resolved, that a copy of this resolution be spread upon the minutes of this meeting and that copies of it be sent to (1) all members of the Senate and (2) the American Medical Association.

THE PRESIDENT: These four resolutions will be referred to Reference Committee "C".

DR. WILLIAM WALTON, Belleville: I have two resolutions from the St. Clair County Medical Society.

8. *Unwarranted Attacks on the Medical Profession by its Own Members*

Whereas, the Illinois State Medical Society has always been solicitous of the welfare of the public, as well as the deportment of its members,

Therefore be it resolved, that the Illinois State Medical Society deplores the unwarranted attacks on, and the criticism of, the medical profession by its own members and others, as well as the utilization of media other than the proper medical tribunals and forums available for such purposes.

9. *Elaboration of Medical Ethics*

Whereas, the patients and the public have accepted and approved the joint activities of doctors of medicine upon individual cases involving surgery, or in cases involving diagnosis and treatment only, all to the benefit of the patient; and

Whereas, in many communities there have been joint activities by doctors of medicine, and one bill rendered therefor, with the consent, expressed or implied, of the patient, or his legal representative, one physician acting as agent for the other. Physicians and surgeons have, in their activities of rendering joint services to the patient with the patient's consent, collected the fee on one statement and have thereby fulfilled their plain and palpable duty to their fellow men and have had due regard to all of the circumstances of each particular situation and relation; and

Whereas, in many instances patients have expressed their own desire for one bill, the payment of the bill at one place, and so by custom it has become an accepted practice in many communities; and

Whereas, public policy is the community common sense and common conscience extended and applied throughout the nation to matters of public morals, public health, public safety, public welfare and the like;

Therefore be it resolved, that the following definitions, policies and procedures, for purposes of clarification, be hereby again restated and adopted and approved by the Illinois State Medical Society and that such clarification be brought to the attention of the A.M.A. for their restatement, adoption and incorpo-

ration in the Principles of Medical Ethics of the A.M.A.; and

Be it further resolved, that a copy of this resolution be submitted to the Board of Trustees of the A.M.A.:

1. Definition of Terms:

A. *Fee Division or Divided Fees:*

An ethical sharing of fees between two or more physicians for active participation in the medical and/or surgical care of a patient with the expressed or implied knowledge of the patient.

(1) In legal partnership of doctors, or clinics of doctors, or where doctors have joined together in the practice of medicine, and so hold themselves to the public and patients, where all income and expenses are joint account or joint venture, it is ethical and legal for the members of the group to confer and care for a patient and to render one fee bill to the patient, and the income shall be divided in accordance with their contract basis or salary or percentage arrangement.

(2) Where two or more doctors render services to a patient, one statement may be submitted to the patient by either doctor, itemizing each doctor's charge, and the entire bill may be paid to either doctor, who in turn will forward the other doctor the amount called for in said statement.

(3) Each physician may, if he so desires, render to the patient an individual bill for his individual services, rather than the procedures elaborated in paragraphs (1) and (2).

2. The officers of the American Medical Association be respectfully requested to advise the president or Chairman of the Council of the Illinois State Medical Society in respect to the disposition and action taken, after due consideration by the American Medical Association.

THE PRESIDENT: These two resolutions will be referred to the Committee on Miscellaneous Business.

DR. E. H. WELD, Rockford: I have a resolution from the Winnebago County Medical Society.

10. *Method of Collecting Funds for the American Medical Education Foundation*

Whereas, it has been shown that the cost of medical education in the United States has reached the highest level ever, and

Whereas, in order to help the medical schools to meet increased costs, the American Medical Association established the American Medical Education Foundation; and

Whereas, many physicians in the United States saw the need for such a fund and contributed voluntarily to it; and

Whereas, many physicians contribute directly to their own medical schools in addition to or instead of to the American Medical Education Foundation; and

Whereas, the Illinois State Medical Society, at its annual meeting in May of 1952, established as a part of its 1953 dues a compulsory twenty dollars ($20.00) per member contribution to the American Medical Education Foundation; and

Whereas, it has been determined that many members of the Illinois State Medical Society are opposed to such a method of contributing to the American Medical Education Foundation because of the compulsory nature of the contribution; and

Whereas, it has been determined that no other State Medical Society has collected funds for the American Medical Education Foundation as a compulsory collection in the form of dues; and

Whereas, it is inequitable that the members of the Illinois State Medical Society should be the only physicians in the United States being compelled to contribute to a National Fund; and

Whereas, a careful study of the methods of collection of American Medical Education Funds throughout the Nation has shown that of all the other State Societies only the New York State Medical Society collects for the National Fund through its dues and then only in a voluntary manner; and

Whereas, the American Medical Association records show that the physicians in Illinois in 1952, voluntarily contributed thirty-seven thousand one hundred and twenty-one dollars ($37,121) to the Fund and thus established a rank of fourth place in the entire Nation;

Now therefore be it resolved, that the Illinois State Medical Society continue to collect American Medical Education Foundation funds from its members, but on a voluntary system rather than a compulsory system and that the delegates of the component County Societies of the Illinois State Medical Society be instructed to support this resolution and that a copy of this resolution be forwarded to the House of Delegates of the American Medical Association.

THE PRESIDENT: This resolution will be referred to Reference Committee "A".

DR. WELD: The second resolution which I have was not presented to the Winnebago County Medical Society but was concurred in by the delegates from that Society here present.

11. *Increase in the Annual Dues of the American Medical Association to Provide Sufficient Support for the American Medical Education Foundation*

Whereas, it is generally recognized that medical education in the United States is in need of financial support, and

Whereas, The Illinois State Medical Society assessed each member $20.00 for 1953 to be contributed to the American Medical Education Foundation, and

Whereas, it seems inquitable that, of all the States the Illinois State Society should be the only Society

compelled to contribute to the support of all medical schools in the country;

Whereas, the American Medical Association has sponsored the formation of the American Medical Education Foundation;

Therefore be it resolved, that the Illinois Delegates to the American Medical Association be instructed to present a resolution to the American Medical Association recommending that the annual dues of the American Medical Association be increased by an amount deemed necessary to provide sufficient support to the American Medical Education Foundation, not to exceed $20.00 per member, per annum;

Be it further resolved, that the American Medical Association collect these dues from each member in the same manner as they collect their annual dues.

THE PRESIDENT: This resolution will be referred to Committee "A".

DR. HARRY MANTZ, Alton: I have a resolution from the Madison County Medical Society.

12. *Old Age Assistance*

Whereas, consultants referring surgical cases are not adequately compensated for their services;

Whereas, present regulations restrict a physician for his patients;

Therefore be it resolved, that the Committee on Old Age Assistance of Illinois State Medical Society attempt to raise the fee to consultants on surgical cases, and

Be it further resolved, that present regulations regarding prescriptions be changed to allow the physician freedom in his choice of medicine for his patients.

THE PRESIDENT: This resolution will be referred to Committee "B".

DR. F. E. BOLLAERT, East Moline: I have two resolutions from the Rock Island County Medical Society.

13. *Division of Fees*

Whereas, there has been much confusion in the medical profession on the ethical problems of commissions and the division of fees;

Be it resolved, that the Illinois State Medical Society adopt an Elaboration of Medical Ethics such as that of the Iowa State Medical Society;

Be it further resolved, that upon adoption of this resolution, delegates of the Illinois State Medical Society be requested to advance this resolution to the A.M.A.

14. *Illinois Senate Bill No. 381.*

This resolution was proposed by the Rock Island Chapter of the Illinois Academy of General Practice.

Whereas, a bill S. 381 pertaining to fee splitting, has been introduced into the Illinois Senate by Senator (Mantell) of Chicago, and

Whereas, this bill lacks proper definition and is open to wide interpretation, and

Whereas, the proposed penalty is intolerably disproportionate to the seriousness of the alleged offense, and

Whereas, the question of division of medical fees is a problem of medical ethics which should be resolved by the A.M.A., and

Whereas, the United States Supreme Court has ruled favorably on the division of fees, and

Whereas, such proposed laws would set up business standards for the medical profession which are unheard of in any other business or professional field,

Therefore, be it resolved, that the Illinois State Medical Society use all means at its command to oppose this bill S. 381.

Be it further resolved, that the Illinois State Medical Society request of the A.M.A. that the sponsoring of such bills without A.M.A. consent shall be deemed unethical.

(NOTE: It is alleged that Senator Mantell is also sponsoring Chiropractice bills.)

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

DR. PERCY E. HOPKINS, Chicago: I rise to a point of order. The Academy of General Practice has no standing in this body.

DR. BOLLAERT: I introduced the resolution as directed by the Rock Island County Medical Society.

THE PRESIDENT: Point of order sustained.

DR. J. A. PETRAZIO, Ava: I have two resolutions from the Jackson County Medical Society.

15. *Insurance Forms*

Whereas, the Jackson County Medical Society of Jackson County, Illinois, did on April 28, 1953, discuss, comment, and constructively criticize insurance forms, and

Whereas, said insurance forms are found lengthy and of different phraseology for each Insurance Company, and

Whereas, consideration and closer cooperation between medical profession and insurance industry is a desirable development of short standardized forms in simple phraseology is deemed advisable,

Now, therefore be it resolved, by the Jackson County Medical Society of Jackson County, Illinois that a more uniform, simple, and standard phraseology of insurance forms be manifested to assist individual physicians of the medical profession.

(Signed)
By J. A. PETRAZIO, M.D.
President, Jackson Co. Med. Soc.

Attest: Edward K. Ellis, M.D., Secretary, Jackson Co. Med. Soc.

THE PRESIDENT: This resolution will be referred to Committee "B".

16. *Opposition to Future Assessment and/or Increase in Dues Unless Certain Procedures Are Complied With.*

Whereas, the House of Delegates of the Illinois State Medical Society have raised the dues for 1953 in the amount of $20.00, and

Whereas, this increase in dues is to be used to help support medical schools, and

Whereas, the individuals making up the membership of the Jackson County Medical Society are required to pay this assessment on pain of expulsion from the Illinois State Medical Society by reason of non-payment of dues, and

Whereas, the bulk of the membership of Jackson County Medical Society had no opportunity to discuss, accept, or reject the action of the House of Delegates, even though as individuals they may or may not have been in sympathy with such action,

Therefore be it resolved, that the Jackson County Medical Society go on record as being unalterably opposed to any future assessment and/or increase in dues unless the following procedure obtains:

(1) Place the proposed assessment and/or increase in dues before the House of Delegates in one regular session of the Illinois State Medical Society.

(2) Vote on the proposal at the following regular session of the Illinois State Medical Society.

Be it further resolved, that a copy of this resolution be sent to:

(1) Committee on Resolutions, Illinois State Medical Society.

(2) Each Secretary of the component Medical Societies of the State, with an earnest request that he place this resolution in the hands of their delegates and alternates.

(Signed)
J. A. WEATHERLY, M.D., Chairman
E. R. CARMEN, M.D., Member
M. J. HUGES, M.D., Member

THE PRESIDENT: This resolution will be referred to Committee "A".

DR. E. P. JOHNSON, Casey: We doctors in Clark County feel there is a definite lack of liaison between the doctors and the legislators. We are informed by legislators that other groups, such as the Osteopaths, do have excellent liaison with the State Legislature. Therefore, we would like to present this resolution.

17. *Closer Liaison Between the Medical Profession and the State Legislature.*

Whereas, in each session of the Illinois General Assembly many bills are introduced which if enacted into law are detrimental to the medical profession, and in many cases are detrimental to the welfare and health of the people of the State of Illinois; and

Whereas, the members of the medical profession should be informed of such intended legislation and also know the voting record of the members of the General Assembly on such matters, in order to protect members of the medical profession and protect the welfare and health of the people of the State of Illinois;

Now, therefore be it hereby resolved, that the Illinois State Medical Society publish in the Medical Society Journal the voting record of the members of the Illinois General Assembly prior to primary elections and prior to general elections, and

Be it further hereby resolved, that a layman representative be kept at the State Capitol by the Illinois State Medical Society at all times during the sessions of the Illinois General Assembly for the purpose of keeping members of the medical profession informed as to different bills that are introduced in each session affecting the medical profession and the welfare and health of the people of the State of Illinois, and

Be it further hereby resolved, that said layman representative work in conjunction with the Illinois Medical Society and its members in securing passage in the General Assembly of bills which are favorable to the practice of medicine in the State of Illinois in such a manner and in such ways most beneficial to the welfare and health of the people of the State of Illinois; and

Be it further hereby resolved, that all members of the medical profession in the State of Illinois shall take an active interest in helping to secure the election at primary elections and general elections of members of the General Assembly whose voting records and actions prove them to be working for the welfare and health of the people of the State of Illinois and for the betterment of the medical profession of this state.

THE PRESIDENT: The resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Bernard Klein, Chairman.

DR. J. HOWARD MALONEY, Rockford: This resolution was adopted by the Winnebago County Medical Society May 8, 1953, and the delegates from Winnebago County were instructed to present it at this meeting.

18. *Appointment of a Special Committee for the Study and Dissemination of Material of Legislative Interest.*

Whereas, much of the published material from the Committee on Medical Service and Public Relations has concerned legislative problems, and

Whereas, the State Medical Society Constitution makes no mention of legislation as part of the duties of said Committee,

Therefore, be it resolved, that the House of Delegates of the Illinois State Medical Society request the President to form a special committee for the study and dissemination of material of legislative interest, and

Be it further resolved, that the Committee on Medical Service and Public Relations plan an aggressive program which will keep each component Society of the Illinois State Medical Society abreast of Public Relations activities of other county and state medical societies and the American Medical Association within the definition of its duties in the constitution.

(Signed) J. H. MALONEY, NORMAN L. SHEEHE

THE PRESIDENT: This resolution will be referred to the Committee on Reports of Standing Committees.

DR. G. E. HARTENBOWER, Bloomington: At the meeting of the McLean County Medical Society on

March 10, 1953, as the delegate from our society, I discussed the so-called Iowa proposal on medical ethics, and requested that the McLean County Medical Society go on record as to whether they wanted me to state they were for or against this particular proposal. I was instructed by the Illinois State Medical Society to ask for this opinion. The following resolution was presented to the Society. It was moved by Dr. Boon that the resolution be placed before the Illinois State Medical Society. The motion was seconded by Dr. Wellmerling and passed unanimously.

19. *Elaboration of Medical Ethics*

Whereas, there has been much confusion in the medical profession on the ethical problem of commissions and fee splitting,

Be it resolved, that the McLean County Medical Society adopted elaboration of medical ethics such as that of the Iowa State Medical Society, and

Be it further resolved, that our delegates advance this resolution for adoption by the Illinois State Medical Society, and

Be it further resolved, that the Illinois State Medical Society be requested to advance this resolution to the American Medical Association.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

THE SECRETARY: I have a resolution from the Montgomery County Medical Society.

20. *Elaboration of Medical Ethics by the State of Iowa Medical Society.*

1. When two or more doctors actually and in person render services to one patient, and the doctors desire to submit one statement to the patient for the services rendered, it should be made clear to the patient or his legal representative that this is to be divided equitably among all physicians who have rendered services and the patient's consent, either expressed or implied, obtained as to such procedure. This fee may be entirely paid in its entirety to either physician and the one receiving payment shall forward the other his fee.

2. In legal partnership of doctors, or clinics of doctors, or where doctors have joined together in the practice of medicine, and so hold themselves out to the public and patients, where all income and expenses are joint account or joint venture, it is ethical and legal for the members of the group to confer and care for a patient and to render one fee bill to the patient, and the income shall be divided in accordance with their contract basis or salary or percentage arrangement.

3. Where two or more doctors render services to a patient, one statement may be submitted to the patient by either doctor itemizing each doctor's charge and the entire bill may be paid to either doctor who in turn will forward the other doctor the amount called for in said statement.

4. Each physician may, if he so desires, render to the patient an individual bill for his individual services, rather than the procedures elaborated in paragraphs 1, 2 and 3.

The Montgomery County Medical Society at its regular meeting on December 9, 1952, adopted the following resolution:

Whereas, there has been much confusion in the medical profession on the ethical problems of commissions and of fee-splitting,

Be it resolved, that the Montgomery County Medical Society adopt an Elaboration of Medical Ethics such as that of the Iowa State Medical Society.

Be it further resolved, that our delegates advance this resolution for adoption by the Illinois State Medical Society.

Be it further resolved, that the Illinois State Medical Society be requested to advance this resolution to the A.M.A. for adoption.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

THE SECRETARY: I also have a resolution from the DeKalb County Medical Society.

21. *Elaboration of the Principles of Medical Ethics*

The DeKalb County Medical Society, at the meeting held March 24, 1953, voted to support the Iowa Elaboration of the Principles of Medical Ethics. A motion was amended to transmit this information to the State Secretary to be presented to the Chairman of the House of Delegates.

(Signed) CARL E. CLARK, M.D., Secretary

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

DR. W. E. KITTLER, Rochelle: At a regular meeting of the Ogle County Medical Society held April 28, 1953, it was moved by Dr. Beebe that the Rock Island County resolutions pertaining to fee-splitting and unauthorized public statement by members of the A.M.A. be endorsed by Ogle County. The motion was seconded by Dr. Drennen and carried. These resolutions are as follows:

22. *Publicity and Fee-splitting Publicity*

Whereas, certain recent news articles have left a public impression that a large part of the medical profession is disreputable, dishonest, unethical and unscrupulous, and

Whereas, these news items have brought before the public highly controversial matters pertaining to medical conduct which should be resolved within the profession itself, and

Whereas, such publicity has been used to further the interests of one group at the expense of the others, and

Whereas, such publicity has disgraced the entire profession, and

Whereas, such publicity does not constitute a matter of public policy, and

Whereas, a minority group has attempted to use outside agencies, such as Blue Shield and the Department of Internal Revenue to enforce certain of its questionable rules of ethics upon the entire medical profession, and

Whereas, use of such autocratic, dictatorial powers by a minority group does not comply with ordinary and fundamental principles of democracy,

Be it resolved, that the Ogle County Medical Society request its delegate to the State Convention to present this resolution to the proper committees with the request that the Illinois State Medical Society adopt and advance it to the proper national committees of the A.M.A. at its next session for adoption.

Whereas, the airing in lay periodicals of controversial matters pertaining to the medical profession can do nothing but create poor public relations and bring distrust and unjust criticism on the profession, which has always justly been held in high public esteem,

Be it further resolved, that it shall be considered unethical for any medical group or individual to sponsor, support or condone any publications in lay journals or newspapers, radio or T.V. broadcast of any controversial issues pertaining to the medical profession except with the expressed consent of the A.M.A. or its component societies.

Be it further resolved, that the State Society shall present these resolutions to the proper committee of the A.M.A. for its adoption as part of the A.M.A. Code of Ethics.

Therefore, be it resolved that the A.M.A. rebuke such action of minority groups.

Fee-Splitting

Whereas, there has been much confusion in the medical profession on the ethical problems of commissions and the fee-splitting,

Be it resolved, that the Ogle County Medical Society adopt an Elaboration of Medical Ethics, such as that of the Iowa State Medical Society.

Be it further resolved, that our delegates advance this resolution for adoption by the Illinois State Medical Society, and

Be it further resolved, that the Illinois State Medical Society be requested to advance this resolution to the A.M.A.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

THE SECRETARY: I have a resolution from Franklin County Medical Society which was adopted at its meeting on November 19, 1952.

23. *Elaboration of Medical Ethics*

Whereas, there has been much confusion in the medical profession on the ethical problems of joint fees,

Be it resolved, that the Franklin County Medical Society adopt an Elaboration of Medical Ethics such as that of the Iowa State Medical Society, and

Be it further resolved, that the Illinois State Medical Society be requested to advance this resolution to the American Medical Association for adoption.

THE PRESIDENT: This will be referred to the Committee on Miscellaneous Business.

THE SECRETARY: I have another resolution passed by the Vermilion County Medical Society in regular session on May 5, 1953.

24. *Undesirable Publicity in Lay Journals*

In view of the fact that a recently published interview with Dr. Paul Hawley in the U.S. News and World Report, and reprinted in the May issue of the Readers Digest, with a malicious criticism of the practice of medicine in the United States,

Be it resolved by the Vermilion County Medical Society that the delegate and alternate delegate to the Illinois State Medical Society be instructed to support any motions or resolutions presented at the forthcoming Illinois State Medical Society's annual meeting which will condemn, denounce and prevent such public criticism by such individuals or groups; and that a copy of this resolution be forwarded to the Secretary of the Illinois State Medical Society and to the Secretary of the American Medical Association.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

THE SECRETARY: There are two resolutions from the Chicago Medical Society.

25. *Publicity by Dr. Paul R. Hawley*

Whereas, Dr. Paul R. Hawley, the Director of the American College of Surgeons, who lists his address as 40 East Erie Street, Chicago, Illinois, a general practitioner and not a member of the American Medical Association, recently was invited by the editors of the U.S. News and World Report, a lay magazine of national circulation and distribution, to their conference room, where there took place a certain interview appearing in the February 20, 1953 issue on pages 48 to 55, both inclusive, a true and correct copy of which interview is hereto appended as Exhibit A; and it appears that said interview consisted of many questions propounded to and answered by Dr. Hawley, on a variety of subjects touching the medical profession and the conduct of its members, some excerpts of which are as follows:

"Q: Is it your contention, Dr. Hawley, that fee splitting among doctors is wrong?"

"A: Fee splitting . . . results in a lot of bad surgery and a terrible lot of unnecessary surgery. . ."

"Q: Does this ghost surgeon work by an x-ray? How does he know where to cut?"

"A: Of course, he can have anything he may need for the operation but nine times out of ten, no. He just takes the word of the doctor who tells him what he thinks is wrong."

"Q: He is like a butcher?"

"A: A meat cutter. One of my friends likes to call them hewers of flesh and drawers of blood."

"Q: Is there any tendency toward abuse in those things?" (Referring to fees in sickness funds)

"A: On a wide scale, no, in isolated spots, yes. I don't know whether you have noticed it out in

California or not there have been 200 doctors out there who have been chiseling on the Blue Shield Fund. . . ."

"Q: Isn't all this crusading against unethical practices in medicine going to undermine public confidence in physicians?"

"A: Yes, there is that definite reaction to expect My only answer to that would be that the profession has brought it on themselves. . . ."

Whereas, it appears that the answers of Dr. Hawley in said interview contain misstatements and distortions of fact, unfounded and uncorroborated charges, platitudes, innuendoes and generalizations with implications of a pernicious and unsavory nature, individual and collective self-laudation of grandiose proportions, and scurrilous and derogatory remarks tending to bring the medical profession in disrepute and to make it subject to public suspicion, ridicule and scorn; and

Whereas, in an "unprecedented meeting" of the Board of Regents of the American College of Surgeons, as reported in newspapers with national and international coverage on or about September 25, 1952 (see Exhibit B hereto attached), the Regents asked the aid of newspapers — not of medical associations and forums — in educating the public to certain evils, four of the members being directly quoted on the subject; and that the same ideas with unqualified amplifications and ramifications were echoed by Dr. Hawley in his interview above referred to; and

Whereas, it further appears that Dr. Hawley in said interview, when asked about the selection of a doctor, replied ". . . . if I had any choice, ... I would not allow anybody to go into my belly who was not a member of the American College of Surgeons or a diplomate of the American Board of Surgeons;" that he volunteered the statement that "We in the College of Surgeons investigate all possible unethical practice — unnecessary surgery, ghost surgery, fee splitting . . ."; that when questioned, "If a hospital has your certificate on the wall, would it be likely to do this type of surgery (referring to ghost surgery), Dr. Hawley replied, "Oh, no. But we have given up our own certification"; and it appears that all of said answers were self-laudations which "defy the traditions and lower the moral standard of the medical profession" and were deliberately designed to promote and elevate the American College of Surgeons at the expense of all in the medical profession who are not members of said College; and that in view of these public pronouncements and others of a similar vein, there exists a serious doubt as to whether the American College of Surgeons, whose representatives sit on the Board for accrediting hospitals, can render an impartial and unbiased report in the performance of their duties; and

Whereas, the American Medical Association is the supreme voice and authority in all matters pertaining to and affecting the medical profession; that all other constituent organizations, being a part of the whole, cannot be greater than the whole; that the American College of Surgeons, through its director and regents, has attempted to arrogate unto itself vast powers which it does not possess and has held itself out as the palladium of medical virtue; that it would be catastrophic were other organizations within the American Medical Association, seeing this precedent of unbridled and unlicensed newspaper and magazine comments go unchallenged, to issue criminations and recriminations in airing of medical problems through the medium of lay publications, as a consequence of which there would be chaos and confusion of voices and as a result the further undermining of public confidence in the medical profession, and it is therefore necessary that a thorough inquiry and review be made of this entire situation, a policy formulated and established and remedial measures adopted.

Therefore be it resolved, that the Councillors of the Northwest Branch of the Chicago Medical Society present this report of conditions to the earliest meeting of the Chicago Medical Society; and be it further

Resolved, that the Councillors of the Northwest Branch of the Chicago Medical Society actively promote and vote to obtain the approval and recommendation from the Chicago Medical Society that this report of conditions be forwarded in its entirety to the House of Delegates of the Illinois State Medical Society; and be it further

Resolved, that the delegates of the Chicago Medical Society to the Illinois State Medical Society upon approval and recommendation of the Chicago Medical Society actively promote and vote that the Illinois State Medical Society present this report of conditions in its entirety to the House of Delegates of the American Medical Association for inquiry, review, remedial measures and disciplinary action at the earliest possible date.

Dr. Adams stated that the Resolutions Committee recommend that this resolution be accepted and the report, as suggested in the resolution, be sent. On motion duly made, seconded and carried, the Council of the Chicago Medical Society at its meeting on May 1, 1953 voted to adopt this recommendation of the Resolution Committee.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

26. *Elaboration of Medical Ethics*

Whereas, the Principles of Medical Ethics of the American Medical Association and the interpretations thereof have, as a result of recent rather widely publicized, diversified expressions of opinion, been the subject of much discussion among various individuals and many groups within organized medicine; and

Whereas, the resultant differences of opinion have caused considerable unrest and some misgivings within

the medical profession, due primarily to the implications of improper conduct on the part of the profession as a whole because of the improper acts of a small minority of members of the profession; and

Whereas, a number of members of the profession claim as proper the issuance of an itemized joint bill when more than one physician participates actively in the care of a patient, because of local acceptance of the procedure by both the public and members of the profession; and

Whereas, the Principles of Medical Ethics of the American Medical Association, while very explicit in consideration of duties of physicians in consultations and in many other matters of physician relations with one another, do not give sufficient consideration to the duties of physicians in the joint care of a patient;

Therefore be it resolved, that the House of Delegates request the Judicial Council of the American Medical Association to give further consideration to the interpretations of the Principles of Medical Ethics with special reference to proper billing procedures; and

Be it further resolved, that the Committee on Constitution and By-Laws of the American Medical Association, at present engaged in a revision of the Principles of Medical Ethics, be requested to give consideration to the drawing up of an amendment dealing with the duties of physicians in instances of active cooperative care of a patient by two or more physicians, defining proper conduct and responsibilities of the physicians involved in such care, and stating procedures to be followed in properly billing the patient for services rendered to enable the physicians participating in such a case to obtain adequate compensation.

(Signed) GEORGE SCHERIN, EDSON FOWLER, GEORGE TARRY, NORRIS HECKEL, WARREN W. FUREY, EUGENE McENERY, PERCY E. HOPKINS, LEO P. A. SWEENEY, G. HENRY MUNDT, CHARLES B. PUESTOW, EDWIN M. MILLER, WRIGHT ADAMS, Chairman.

This resolution was adopted by the Council of the Chicago Medical Society, March 10, 1953.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

DR. WALTER BAER, Peoria: I wish to present the following resolution:

27. *Adequate Medical Care for the Committed Mentally Ill of Illinois.*

Whereas, there are in the Illinois State Mental Hospitals approximately 47,000 patients, and

Whereas, the Illinois Department of Public Health has certified 32,000 beds for these hospitals, which means that these hospitals are overcrowded by 15,000 patients, hundreds of whom are forced to sleep on the floor, and

Whereas, the budget for the Department of Public Welfare as presented by the Governor contains not one cent of new money for hospital construction and a decreased sum for care and treatment so vitally needed, now therefore

Be it resolved, that the Illinois State Medical Society petition the Governor and the members of the Legislature to provide funds for the provision of necessary beds and for adequate medical care for the committed mentally ill of Illinois.

THE PRESIDENT: This resolution will be referred to Reference Committee "B".

On motion duly made and seconded the House adjourned at 5:05 P.M. to reconvene on Thursday at 3 P.M.



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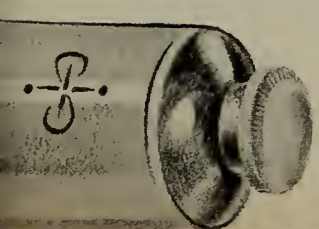
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SAMPLES AND LITERATURE TO PHYSICIANS ON REQUEST

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HISTOPLASMOSIS

Throughout this discussion I frequently have alluded to the marked similarity between the disease process of histoplasmosis and that of tuberculosis. Both are diseases which can affect any system of the body but to which attention has been called primarily through pulmonary manifestations. In both instances, physicians depend upon skin tests and the finding of the organism for positive diagnosis. The skin test may not become positive until late in the disease, and in both, the skin tests may become negative if the patient is overwhelmingly ill or if an intercurrent disease intervenes. The diseases may be found incidental to routine surgery such as removal of the appendix or tonsils. The pulmonary manifestations such as cavitation, empyema, pleuritis, consolidation, and the various radiographic appearances are similar. The radiographic appearance in both diseases suggests a bronchogenic form of spread as well as a hematogenous form of the disease. The portal of entry in both diseases is suggested to be mainly pulmonary, but occasionally oral. The pathologic change in both diseases is a mixture of necrosis, exudation, and proliferation and suggests a granulomatous process. *Daniel Jackson, M.D., Pulmonary Histoplasmosis. Texas J. Med., Dec. 1952.*

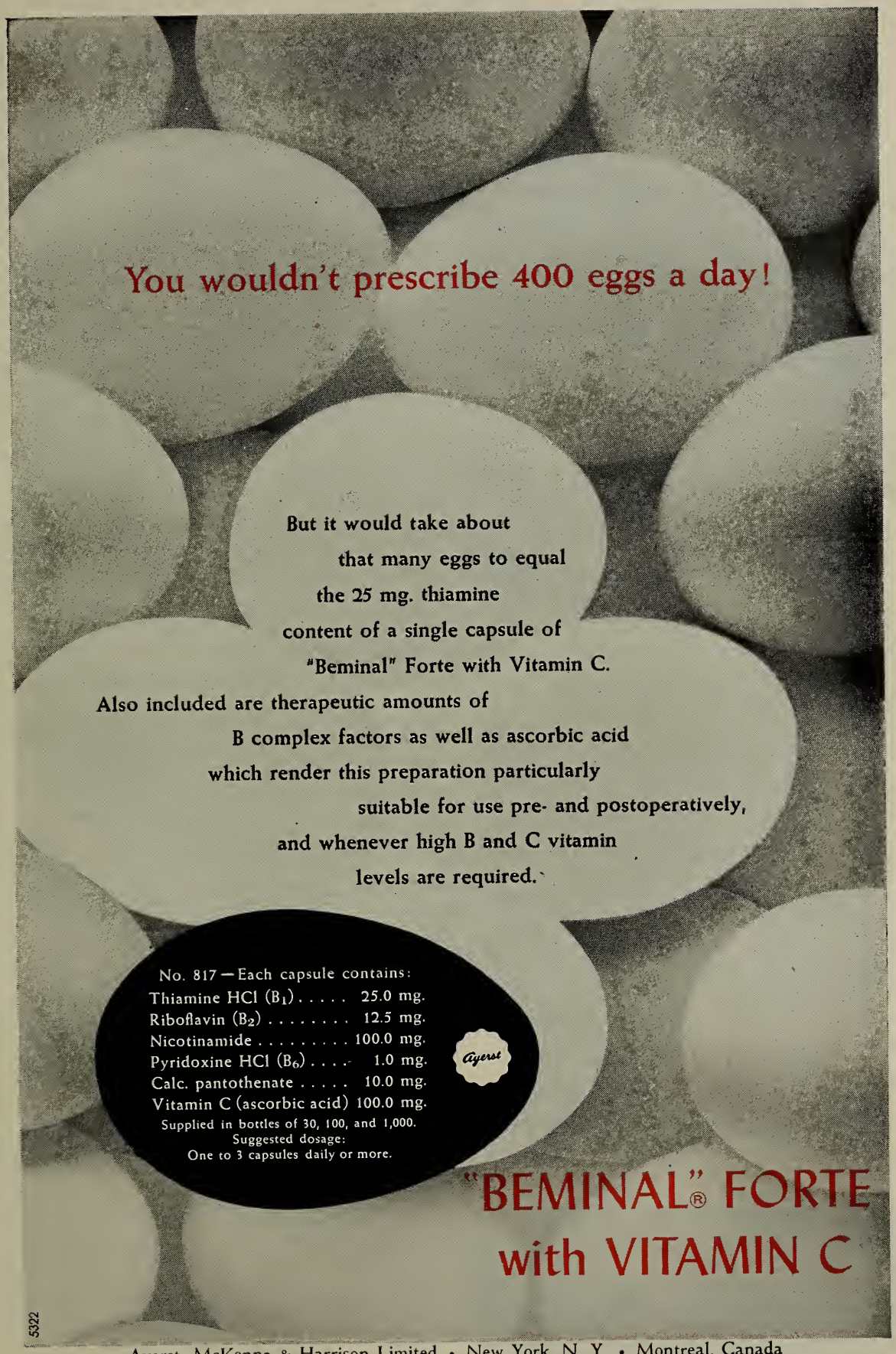
BRITISH HEALTH PLAN

To begin with, one cannot compare the United States and Britain. Traditions in Britain are more important to them than efficiency, and there is pride in this. Moreover, politically and in the mechanisms of medicine, their approach is quite different from ours. The general practitioner usually has his office in his home and sees patients there, in their homes, or at a nursing home. The last is analogous (though much more desirable and seldom over 40 beds) to the private hospital here. There are operating and obstetrical suites but no laboratory or x-ray. These procedures must be obtained through specialists if the general physician cannot do them himself. In addition he must supply his own instruments, gowns, and the like. The hospitals are ward in nature such as our general hospitals and are limited to use by the specialist. Thus one easily can see that the gulf between the general practitioner and the specialist is broad. This has been increased since the adoption of the National Health Service, for the general practitioner is paid $2.38 per head per year for up to 4,000 patients wheras the specialist is given a salary for his hospital work. In addition, he receives some government paid consultations over and above any that he may receive privately. Do you believe that you could see 4,000 patients so often as they desire through a year? Since the change in administration, this is being dropped to 3,500 but there still is a great deal to be desired. What has happened is that the niceties of medicine have increased, to the pleasure of many but the health problem of the nation including tuberculosis, housing, and public health measures has been overlooked — a vote is too important. *James Rogers Fox, M.D., Inside The British Health Plan. Minnesota Med., Feb. 1953.*

INCISIONAL HERNIAS

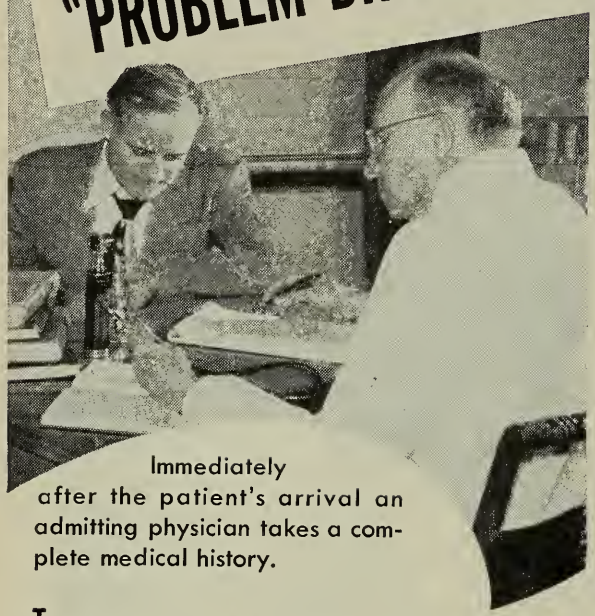
Why do incisional hernias occur? There are causes that may be attributed to the patient and also those associated with surgery. Factors in the patient are either mechanical or delay in healing. Mechanical factors are obesity, coughing, or straining; delay in healing factors are anemia, dehydration, hypoproteinemia, and deficiency in vitamin C. The latter usually are found in cachectic patients, those with carcinoma, and in patients with complications of peptic ulcer. Factors associated with surgery are the incision, the closure, the suture material, and the hospital course. Mid-line incisions are followed commonly by hernia. When two or more nerves of the wall are cut at surgery, muscle atrophy usually follows and an incisional hernia will appear. The abdominal wall receives its nerve supply from 6 to 12 thoracic and first lumbar from the right and left sides. The nerves lie between the internal oblique and transversalis muscles and penetrate the rectus sheath laterally, extend medially on the anterior surface of the posterior rectus sheath, and enter the rectus muscle near the mid-line of the abdomen. Anatomical incisions that spare the nerves (for example, McBurney, transverse, and Pfanensteil) rarely are followed by hernia. Paramedian incisions are more often followed by hernia because of the difficulty in good closure of the

(*Continued on page* 38)



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HERNIAS (Continued)

tense posterior shealth. Non-anatomical incisions, chiefly the rectus muscle splitting and mid-line, are most frequently followed by hernia. *James G. Garland, M.D., Incisional Hernia. Wisconsin M.J., Nov. 1952.*

BLOOD FOR DEFENSE

Blood, not unlike petroleum, is a limited natural resource. It has been quite a problem to meet the quota of 3,000,000 pints set by the department of defense for a one year period, even though this represents only one donation a year by less than 2 per cent of our population. In a period of grave national crisis represented by World War II, the American National Red Cross collected only 13,000,000 pints of blood in a four and one-half year period. Many individuals gave on numerous occasions so that the 13,000,000 pints represent fewer than 13,000,000 individuals. Many millions of pints of blood and plasma would be required in a short space of time in case of surprise large scale atomic attack on our country. *Tibor J. Greenwalt, M.D., Conservation Of Blood. Wisconsin M.J., Dec. 1952.*

FRACTURED RIBS

There are various methods of treating simple rib fractures. Taping is satisfactory in many cases, but in females the breasts often interfere. For taping fractures of the lower ribs, one ought to position the patient on a stool and then snugly apply strips of 2 inch tape from the paravertebral area posteriorly on the side opposite the injury, around the chest, over the fracture, ending up anteriorly across the midline opposite the side of the injury. Four to six strips overlapping one another from below to above the fracture level usually will suffice. The strips should be applied in expiration, for the chest cage is maximally relaxed during this phase and consequently will be more effectively immobilized. Should the fracture be in the upper third or fourth ribs, several strips extending across the clavical from front to back will immobilize the upper chest sufficiently to relieve pain. These should be applied in deep inspiration to suspend the ribs and prevent excursions with respirations. When the patient will not tolerate taping, the wearing of a tight fitting vest may give the desired comfort. *Cecil G. McEachern, M.D. and Justin E. Arata, M.D., Treatment Of Chest Injuries. J. Indiana M.A., Feb. 1953.*

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I said before that the most helpful thing that can be done to advance fundamental science is to find the truly gifted scientists and support him to the utmost. Let me repeat this for the individual who can integrate the current stream of emerging knowledge. Only too often his work does not receive the recognition it deserves, and his labors are performed at the sacrifice, not only of his own career in strictly novel research, but also of his scale of living, for the direct rewards of this sort of publication are not large. I wish there were more generous support for labor of this sort and more recognition for this type of attainment. *Vannevar Bush, D. Eng., Sc.D., "We Are In Danger Of Building A Tower Of Babel." Pub. Health Rep., Feb. 1953.*

IRRADIATION IN LEUKEMIA

X-radiation remains the treatment of choice in most cases of leukemia and lymphoma but new agents are playing an increasing role in therapy. Radioactive phosphorus does not produce radiation sickness and results with it are comparable to those of x-ray therapy in chronic leukemia. Urethane and nitrogen mustard may produce remissions in patients with chronic leukemia who have become resistant to radiation. Triethylene melamine may be administered orally with nitrogen mustard-like effects and is undergoing further trial. Aminopterin, ACTH, and cortisone often cause short remissions in acute leukemia. Urethane is the best treatment available for multiple myeloma. Polycythemia vera is well controlled by radioactive phosphorus combined with venesection. Nitrogen mustard often is effective and triethylene melanine shows promise in Hodgkin's disease. Anti-anemic substances such as iron and liver extract are of no value in the treatment of anemia caused by leukemia, lymphoma, and myeloma. *Arthur A. Marlow, M.D. and Grant R. Bartlett, Ph.D., Newer Therapy For Leukemia, Polycythemia, And Lymphoma. California Med., Feb. 1953.*

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1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Shafiroff, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.



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THE CAUSE OF PRISON RIOTS

These are tense days for prison administrators and we hesitate to talk about prison riots even with our fingers crossed. My psychiatric and psychological friends have a great facility for finding in the manful background of our inmates some situation or some kind of handicap that gave rise to an anxiety — which in turn motivated their conduct. And when these analysts of human behavior cannot pin down the specific anxiety that is the basis of their maladjustment, they say that the individual has a free-floating anxiety. This is a fear or a conflict of an anxiety that flits from one thing to another. We in the prison business just now are afflicted not with one but a lot of free-floating anxieties. First are the problems presented by obsolete and inadequate plant and equipment. Of the 152 state prisons and reformities housing about 150,000 persons, about one-third are more than 70 years old and a few, like the Massachusetts State Prison at Charlestown and the Maryland State Prison in Baltimore, are just short of being 150 years old. Right here in Pennsylvania, you have one or two antique millstones that go back to the days when solitary confinement, the treadmill, oakum picking, and preachments were thought to be the way to salvage the wrongdoer. The second shortcoming of American prisons is personnel. What kind of person can you get nowdays to take on the job of guarding men — let alone counsel and guide them — for an average take home pay of $50. per week? The third handicap the prisons face is lack of program. Idleness stalks almost every prison. Men mill aimlessly about crowded yards or remain locked in cells or quarters hour after hour and day after day with nothing to do but gripe and connive and learn new crime techniques. The fourth major factor accounting for unrest is the increase in the prison population of the vicious, assaultive, aggressive, and psychopathic. *James V. Bennett, The Significance Of prison Riots. Philadelphia Med., Mar. 21, 1953.*

Of the million hospital beds needed during the next 15 or 20 years, two thirds will be for the chronic sick, including mental and tuberculous patients. A. P. Merrill, M.D., New York State Medical Journal, October 1, 1952.

Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. *6*:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

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BOOK REVIEWS



ESSENTIALS OF INFANT FEEDING FOR PHYSICIANS. Herman Frederick Meyer, M.D., Assistant Professor of Pediatrics, Northwestern University School of Medicine; Associate Attending Physician, Children's Memorial Hospital, Chicago, Illinois. Charles C. Thomas, publisher, Springfield, Illinois. $7.75.

There are few fields in medical practice so easily invaded by the glib-tongued detail man as that of infant feeding. Our salesman is aided and abetted in his efforts by a deep longing on the part of the busy doctor for some sort of infant feeding which would pacify both babe and mother. Since there is no such panacea, the doctor becomes confused and bewildered at the multiplicity of infant foods offered for his use and frequently misses an all-too-obvious cause of trouble through lack of a simple working knowledge of the basic principles of infant feeding.

As the cover states, this is a practical text for rapid reference, and, to quote the foreword by the late Philip C. Jeans: Fills a need existing "for the presentation of the principles of infant feeding in the simplest possible terms and in a manner that makes these principles easily and practically applicable".

Beginning with a brief history of Infant Feeding, the author advances by logical steps through newer work on the subject including a clarification of the meaning and significance of Curd Tension, to an excellent appraisal of the technic of breast feeding and its problems. Then follows a chapter on the chemical principles of infant feeding after which the entire field of artificial feeding is discussed, beginning with the mechanics involved and continuing through formula construction, proprietary foods, solid food supplements and vitamine allowances. Dr. Meyer's observations on psychological feeding problems, self-demand feeding and the "Rooming-In" Plan are those of a seasoned pediatrician. An interesting appendix and a bibliography complete the book.

There are thirteen illustrations and an excellent index. The typography is pleasing to the eye and the author's smooth, informal style makes this handbook a concise and valuable addition to the working library of the busy physician.

J. C. McK.

AN ATLAS OF ANATOMY. By J. C. Baileau Grant, M.C.M.B., Ch.B., F.R.C.S. (Edin). Professor of Anatomy in the University of Toronto. By Regions, Third Edition. Published in Baltimore by the Williams and Wilkins Company 1951. 637 illustrations. Price $12.00.

The first edition of this atlas was published in 1943, reprinted in 1945 and again in 1945; the second edition was published in 1947 and was reprinted in 1948 and again in 1949 and then this third edition was printed in 1951.

This anatomical work deserves a space in any physician's library and such a space as makes it immediately available for reference on any anatomical question. It is clear and almost third dimensional in its depiction of anatomy.

The idea of this Atlas as set forth in the first edition, and is continued in this, the third edition. Namely the observations and comments are designed to attract attention to salient points, and to points of significance

(*Continued on page* 48)



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that might otherwise escape notice. Their purpose is to interpret the illustrations. These are not, nor are they intended to be, exhaustive descriptions.

The authenticity, or absolute correctiveness of the illustrations is realized when one knows the manner in which they were made. Each specimen was saved and photographed. From this negative film an enlarged positive film was made; tracings of structures from the enlarged film were scrutinized against original specimen to insure correctness. This tentative tracing was then sent to the artist, who with the original dissection at hand made a plastic drawing in which the important features were brought out. Thus little, if any, liberty has been taken with the anatomy. With such technique as to detail only accuracy can result.

Perhaps one of many excellent ideas portrayed in this Atlas is the illustrations of the interior anatomy of various joints. The relative relationship of adjacent structures is well brought out by the various views of the joint with "cut aways" showing different angles. This is quite unique and very interesting as well as instructive.

Color is used, often in a diagnostic manner to intensify the relative position and size of the structure.

The arrangement of the subject matter is excellent and certainly makes for ease in finding the desired item. It also makes for less reduplication of illustrations.

All of the illustrations are made of the right half of the body unless otherwise noted.

This is indeed a visual anatomy.

C. P. B.

MALIGNANT DISEASE AND ITS TREATMENT BY RADIUM. By Sir Stanford Cade; K.B.E., C.B., F.R.C.S., M.R.C.P., F.F.R. (Hon.). Volume IV, Second Edition. Williams & Wilkins Co., Baltimore. 1952, 543 pages. Price $12.50.

The first edition of this work was printed in 1940. The second edition is unfortunately being printed piece meal; Volume 1 in 1948, Volume II, 1949; Volume III, 1950 and Volume IV in 1952. This piecemeal fact slows down one's enthusiasm for a work otherwise commendable. One looks and looks searching for a particular subject. However, if once located and it happens to be in Volume IV information is lucid and almost complete.

Illustrations are numerous. They are for the most part reproductions of "Black & White" photographs, of x-ray films, of charts and of microscopic slides. These latter are for the most part difficult to interpret without functioning imagination.

In a general way, each type of malignancy is con-

(*Continued on page* 50)

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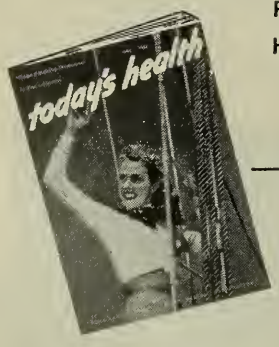
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BOOK REVIEWS (Continued)

sidered methodically under the following sequence: (1) Natural History (2) Types (3) Histology (4) Clinical manifestations (5) The spread (6) Prognosis (7) Choice of method of treatment (8) Indication for radium therapy and manner of treatment (9) Illustrative cases (10) References. This methodical handling leaves little to be said when completed.

The title implies that perhaps the radium treatment of malignancy may occupy a major portion of the text. Such is not the case. Such treatment is detailed but not verbosely nor excessively.

The book is quite readable as to its style. Stated facts are authenticated by references, etc. One's library needs all four volumes of this second edition.

C. P. B.

A Synopsis of Ophthalmology, by J. L. C. Martin-Doyle, M.R.C.S. (Eng.) L.R.C.P. (Lond.) D.O. (Oxon.), Surgeon, Worcester City and County Eye Hospital; Consultant Ophthalmologist to the Ministry of Pensions and Ministry of National Insurance, School Oculist to the County Borough of Worcester and to the Worcestershire County Council. Baltimore: The Williams and Wilkins Company. 1951. Price $4.50.

This handy 238 page book gives a condensed comprehensive review of ophthalmology. The twenty-eight chapters cover the common and most of the rare conditions. There are no illustrations. Where indicated each chapter begins with a short review of the pertinent anatomy and physiology. There is an occasional reference to history, for instance in the chapter on contact lenses the author mentions that the first contact lens was fitted in 1887 when Doctor Saemisch successfully used a blown glass lens to protect an eye of a patient whose eyelid had been destroyed in an accident.

This text should appeal to medical students, to residents in Ophthalmology and to general practitioners, because it will serve as a quick reference and as an outline. However, it will not replace the more conventional eye disease textbooks, for as the author states it was necessary to omit certain detailed descriptions.

L. P. A. S.

Oral Anatomy by Harry Sicher, M.D., D. Sc., Professor of Anatomy and Histology, Loyola University School of Dentistry, Chicago College of Dental Surgery; Guest Lecturer, Northwestern University, Dental School, Chicago. 310 text illustrations, including 24 in color. Second Edition. St. Louis: The C. V. Mosby Company. 1952. Price $13.50.

A fine, thorough textbook dealing with descriptive, regional and applied anatomy for use by students of dentistry and oral surgery is presented as a supplement to works on dental anatomy and human anatomy.

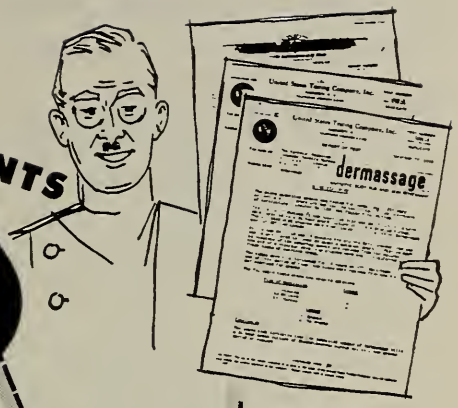
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(*Continued on page* 52)

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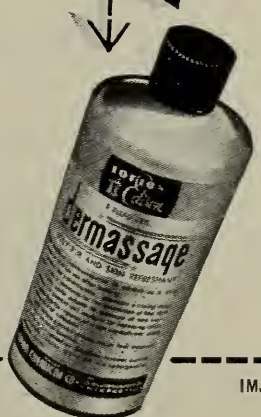
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The other one fourth covers the regional and applied anatomy including chapters on anatomy of local anesthesia on arterial hemorrhages and ligation of arteries, and on tracheotomy and laryngotomy.

The excellent illustrations are in part photographs and in part original drawings and paintings.

Doctor Sicher has done exceptionally well in his attempt to bridge the gap between theory and practice. Dental students and practitioners and oral surgery students and practitioners should find this text highly satisfactory.

L. P. A. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will glady furnish same promptly.

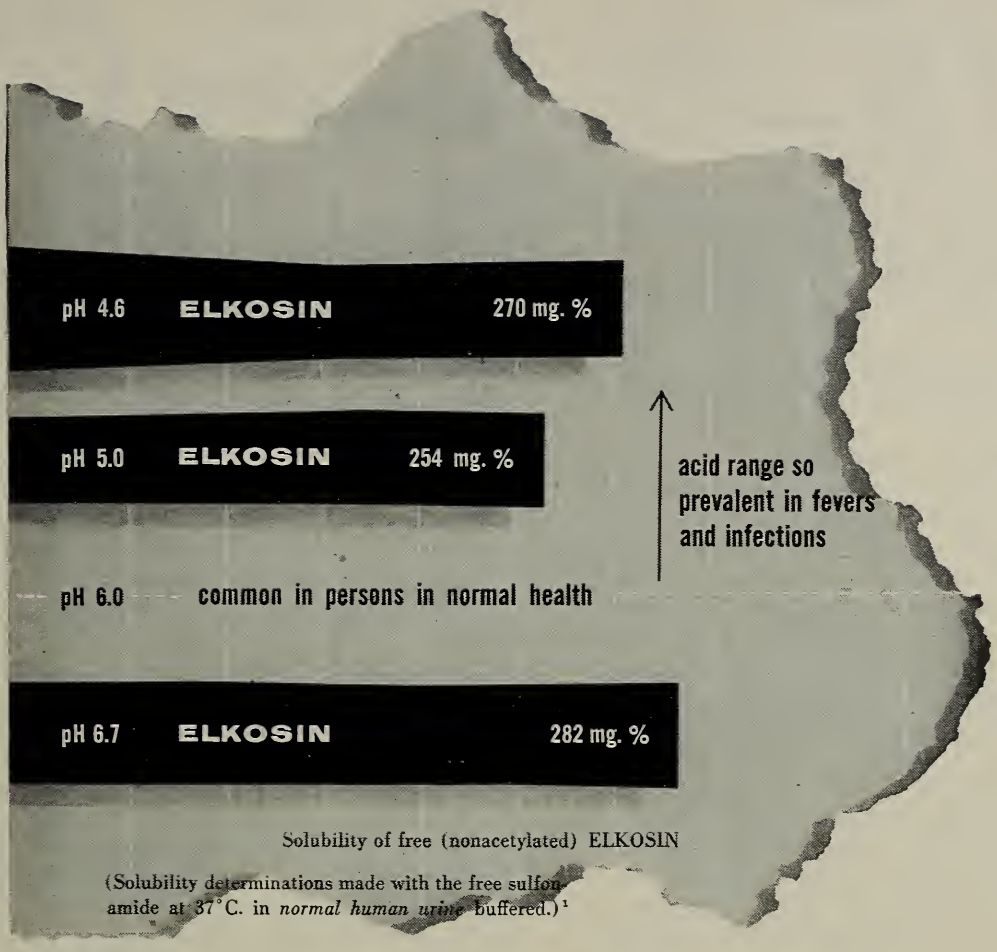
HISTOLOGY. By Arthur Worth Ham, M.B., F.R.S.C., Professor of Anatomy, in Charge of Histology, in the Faculties of Medicine and Dentistry, University of Toronto, Toronto, Canada. 518 figure numbers, including 7 plates in color. Second Edition. J. B. Lippincott Company, Philadelphia, London, Montreal. $10.00.

ROSE AND CARLESS' MANUAL OF SURGERY. For students and practitioners. By Sir Cecil Wakeley, BT., K.B.E., C.B., LL.D., M.Ch., D.Sc., F.R.C.S., F.R.S.E., F.R.S.A., F.A.C.S., F.R.A.C.S., Fellow of King's College, London, President of the Royal College of Surgeons of England. Assisted by eighteen contributors. Eighteenth edition. More than 1000 illustrations, of which many are in colour. The Williams and Wilkins Company, Baltimore. $12.00.

AN ATLAS OF THE COMMONER SKIN DISEASES. By Henry C. G. Semon, M.A., D.M. Oxon, F.R.C.P., London. 147 plates reproduced by direct colour photography from the living subject. Colour photography originally directed by the late Arnold Moritz, B.A., M.B., B.C. Cantab. Fourth edition. The Williams and Wilkins Company, Baltimore. $13.50.

BASIC BACTERIOLOGY, ITS BIOLOGICAL AND CHEMICAL BACKGROUND. By Carl Lamanna, Ph. D., Associate Professor of Bacteriology in The Johns Hopkins University School of Hygiene and Public Health., and M. Frank Mallette, Ph.D.. Associate Professor of Biochemistry in The Johns Hopkins University School of Hygiene and Public Health. The Williams & Wilkins Company, Baltimore. $10.00.

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PSYCHIATRIC DICTIONARY, with Encyclopedic Treatment of Modern Terms, by Leland E. Hinsie, M.D., formerly professor of Psychiatry, College of Physicians and Surgeons, Columbia University, New York; Assistant Director, New York State Psychiatric Institute and Hospital and Jacob Shatzky, Ph.D., Research Librarian, New York State Psychiatric Institute and Hospital. Second edition with supplement. Oxford University Press, New York, $15.00.

THERAPEUTICS IN INTERNAL MEDICINE. By 84 authorities. Edited by Franklin A. Kyser, M.D., F.A.C.P., Assistant Professor of Medicine, Northwestern University Medical School, Chicago; Attending Physician, Evanston Hospital, Evanston, Illinois. Second Edition, Completely revised an reset. A Hoeber-Harper Book. Paul B. Hoever, Inc., 49 East 33rd Street, New York 16, New York. $15.00

SURGICAL FORUM — Proceedings of the Forum Sessions, Thirty-Eighth Clinical Congress of the American College of Surgeons, New York City — September, 1952. Surgical Forum Committee — Owen H. Wangensteen, M.D., F.A.C.S., Minneapolis, Chairman; J. Garrott Allen, M.D., F.A.C.S., Chicago; Warren H. Cole, M.D., F.A.C.S., Chicago; Robert E. Gross, M.D., F.A.C.S., Boston; Carl A. Moyer, M.D., F.A.C.S., Dallas; I. S. Ravdin, M.D., F.A.C.S., Philadelphia; H. B. Shumacker, M.D., F.A.C.S., Indianapolis. 716 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1953. $10.00.

BIOGRAPHY OF AN IDEA — The Story of Mutual Fire and Casualty Insurance. By John Bainbridge, Doubleday & Company, Inc., Garden City, New York. $4.00.

DIURETIC THERAPY. The pharmacology of diuretic agents and the clinical management of the edematous patient. By Alfred Vogl, M.D., Assistant Professor of Clinical Medicine, New York University College of Medicine, Associate Visiting Physician, Third Medical Division Bellevue Hospital; Associate Visiting Physician, Medical Division, Metropolitan Hospital, New York City; Formerly, Associate Visiting Physician, Policlinic Hospital, Vienna, and Clinical Assistant, Guy's Hospital Medical School, London. The Williams & Wilkins Company, Baltimore, 1953. $5.00.

THE PHYSICIAN IN ATOMIC DEFENSE. Atomic Principles, Biologic Reaction and Organization for Medical Defense. Thad P. Sears, M.D., F.A.C.P., Associate Clinical Professor of Medicine, University of Colorado School of Medicine, Chief of Medical Service, Veterans Administration Hospital, Denver; Member of Advisory Staff to Director of Civil Defense, State of Colorado; Member of Disaster Commission, Colorado State Medical Society;

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Colonel (M. C.), U.S.A.R. With a foreword by James J. Waring, M.D., M.A.C.P., Professor of Medicine, University of Colorado School of Medicine. The Year Book Publishers, Inc., 200 East Illinois Street, Chicago. $6.00.

CONFERENCES ON DRUG ADDICTION AMONG ADOLESCENTS. Conferences held at The New York Academy of Medicine, November 30, 1951 and March 13 and 14, 1952, and were sponsored by the Committee on Public Health Relations of The New York Academy of Medicine, with the assistance of The Josiah Macey, Jr., Foundation. The Blakiston Company, New York, Toronto, $4.00.

THE EPIDEMIOLOGY OF HEALTH. A New York Academy of Medicine Book. By Iago Galdston, M.D., Editor. Published by the Health Education Council, New York and Minneapolis, 1953. $4.00.

DICTIONARY OF PSYCHIATRY AND PSYCHOLOGY. (An illustrated Condensed Encyclopedia of Psychiatry, Neurology and Psychology.) By William H. Kupper, M. D., With a foreword by Douglas M. Kelley, M.D., Professor of Criminology, University of California. The Colt Press, Paterson 3, N. J., $4.50.

AN INVENTORY OF SOCIAL AND ECONOMIC RESEARCH IN HEALTH. Compiled by Frederick R. Strunk. Health Information Foundation, 420 Lexington Avenue, New York 17, New York. 1953 edition.

A SHORT PRACTICE OF SURGERY. By Hamilton Bailey, F. R. C. S. (Eng)., F. A. C. S., F. L. C. S., F. R. S. E., Emeritus Surgeon, Royal Northern Hospital, London, Senior Surgeon, St. Vincent's Clinic, and the Italian Hospital; formerly External Examiner in Surgery, University of Bristol, and R. J. McNeill Love, M. S. (Long.), F. R. C. S. (Eng.), F. A. C. S., F. I. C. S., Surgeon, Royal Northern, Mildmay Mission, and Metropolitan Hospitals; Consulting Surgeon, City of London Maternity Hospital; Consulting Surgeon, Potter's Bar Hospital; Associate for General Surgery, West End Hospital for Nervous Diseases; Member of Council and Court of Examiners, Erasmus Wilson Demonstrator, and Hunterian Professor, Royal College of Surgeons, With Pathological Illustrations by L. C. D. Hermitte, M.B., Ch.B. (Edin.) Pathologist, Royal Infirmary, Sheffield. Ninth Edition, 65th thousand. With 1234 Illustrations of which 272 are coloured. The Williams & Wilkins Company, Baltimore, 1953. $12.50.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 56, Art. 2. Pages 141-380. "Comparative Conditioned Neuroses," by Edward J. Kempf and fifteen other leading authors. Editor, Roy Waldo Miner. 300 pages, illustrated, $3.50.

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HIATUS HERNIA

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stances we wish to stress in this presentation. Whenever a patient complains of anginoid symptoms of recurrent epigastric distress, and routine workup fails to reveal any abnormalities, he should not be dismissed until definite and repeated search for a hiatus hernia has been made, regardless of whether or not symptoms are aggravated by supine position. *Lewis F. Baum, M.D. and Otto S. Baum, M.D., Hiatus Hernia. J. Med. Soc. New Jersey. Mar. 1953.*

However accurately we carry out the health examination of the community, we cannot expect to achieve complete victory over infection until the public itself has become better informed. It sometimes happens that an infectious form of primary pulmonary tuberculosis runs such a rapid course that others have been infected long before the next scheduled examination. A flare-up of an older tuberculous infection may also occur rapidly. Such cases are, however, not common and the patient is brought to bed very soon. In many cases the ignorance and asocial, sometimes antisocial, attitude of the sources of infection have contributed to the spread of infection. Tobias Gedde-Dahl, M.D., The American J. of Hygiene, Sept., 1952.

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"Health Officer Examinations—Illinois. August 14, 1953, Qualifying Eligibility Examinations for two local health districts open to qualified public health physicians. Positions: Berwin Health District, salary range $11,000-$15,000; Champaign-Urbana Health District, salary $8500. Write Roland R. Cross, M.D., Director, Illinois Department of Public Health, Springfield, Illinois, Att: Local Health Services."

CANCER IN CHICAGO

A ten year (1937-47) study of cancer incidence in a Chicago area disclosed no significant increase in that city, according to report on a survey released by the National Cancer Institute. Five other cities have previously reported significant increases. Four additional cities are now being surveyed. *Washington Roundup. Ohio M. J. Sept. 1952.*

We have talked about the eradication of tuberculosis as if within a reasonable period that phenomenal condition might become an actuality. It might be well for us to drop this word and think more in terms of possible control. Even though a specific cure or a specific vaccine might be found, it would require generations to discover the last infected person. We look with much pride on the fact that today less than one-half of one per cent of dairy herds in this country are infected. The control program was started in 1916. Its basic features were tuberculin testing, slaughtering of infected animals and, finally, prohibiting the addition of new animals to the herd unless they were tuberculin negative. Thus, for many years this ideal, controlled program has resulted in eliminating the majority of infected cattle before clinical disease has developed and has thereby sharply reduced the chance for spread of infection. Nevertheless, despite these heroic efforts, the significant fact remains that there still exist small reservoirs of infection in our herds. The veterinarian is ever vigilant in his program, for the slightest neglect has again and again proved that, where the tubercle bacillus exists, it can flare into a consuming flame. H. R. Edwards, M.D., The Am. Review of TB, March, 1952.

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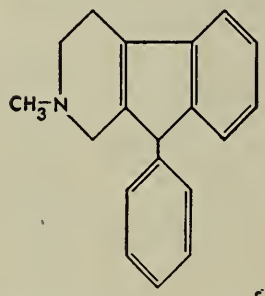
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DOCTORS have long been aware of the need for a really effective filter-tipped cigarette. P. Lorillard Company has been conscious of this problem, and after years of study, experiment and research believes it has developed a cigarette that meets the need.

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The first test involves the drop in skin temperature occurring at the finger tip, induced by smoking and measured according to *well-established procedures*. (b, c)

The second test is a measurement of vasoconstriction in the hand, as recorded plethysmographically. (d)

The results of these measurements—determined for Lorillard by an independent research organization—are shown on the four charts reproduced here. Concurrently, other outside independent laboratories are carrying on further research on the chemical and physiological effects of cigarette smoking *with new and original testing methods*.

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The ILLINOIS Medical Journal

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Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

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Is the B.M.R. Obsolete?

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Dr. Max Samter: Advances in tracer techniques have raised the question whether the BMR actually is a practical contribution to diagnosis and, if not the best at least a reliable guide to treatment. We have asked Dr. Lindon Seed who is in charge of the Isotope Laboratory at Oak Park Hospital to compare the merits of thyroid function tests using radioactive iodine with the merits of the BMR. Dr. Seed is a very articulate individual. I believe that at the end of his presentation he will have left little doubt about his feelings whether or not the BMR is obsolete.

Dr. Lindon Seed: The answer to the question, "Is the basal metabolic rate obsolete?" is "No". Indeed after adding up all the evidence I would say that the basal metabolic rate as a diagnostic test is equal to or superior to the tracer dose of radioiodine. But paradoxically when clinically you are really in need of a diagnostic test in the borderline case the tracer dose is more useful than the metabolic rate.

Figure 1 shows the fate of a tracer dose of 50 microcuries of I^{131} given to a normal person. The thyroid gland immediately begins to accumulate the radioactive iodine. The curve of accumulation rises sharply during the first 6 hours and in 24 hours reaches a plateau which is maintained for several weeks. Once the iodine is trapped by the thyroid gland it either remains within the gland or if it is secreted it is reaccumulated. In the normal person the speed of pick-up is about as depicted here and the final accumulation of about 30% is completed in 24 hours. In the hypothyroid individual thyroid uptake is less than 10% and continues a little longer than one day. In the hyperthyroid patient the final thyroid accumulation is about 70% and is completed much more rapidly. A diagnostic test could easily be based on the 24 hour thyroid uptake alone. Any interval ranging from a few hours to two days could also be used, but 24 hours is a convenient interval and for all practical purposes thyroid accumulation is com-

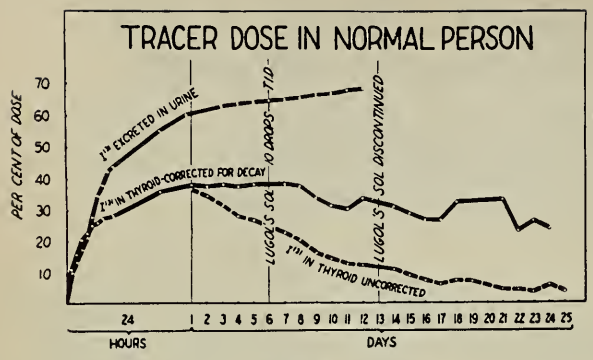


Figure 1

plete in that time in all thyroid disorders. The rate of uptake, since it also varies according to the functional activity of the gland, could be similarly applied as a diagnostic procedure. To calculate the rate at which the thyroid gland clears the I^{131} from the blood stream is feasible but impractical. The radioactive iodine which is not fixed in the thyroid gland is excreted in the urine. As you will note in Figure 1 the curve of urinary excretion rises sharply and also reaches a plateau in 24 hours after which there is very little excretion. In hypothyroidism there is some continued excretion during the second day while in hyperthyroidism it is completed within the first 12 hours. At any time, with the individual shown on this slide at least, one can account for over 90% of the administered dose in either the urine or the thyroid gland. The urinary excretion is almost as accurate a diagnostic criterion as the thyroid uptake. The last few hours of collection, where most of the inaccuracies of an exact 24 hour output will occur, are not very important. It matters little

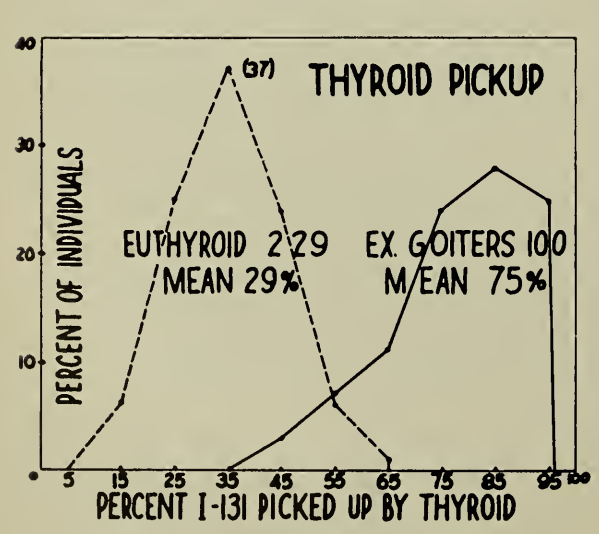


Figure 2

if the specimen is a 20 hour, 24 hour, or 28 hour one as long as it contains the early output. Although most patients will bring back a fairly accurate 24 hour urine collection one can never be absolutely sure.

Figure 2 is a comparison of the thyroid uptake in 229 euthyroid individuals and 100 patients with toxic diffuse goiter. The mean uptake for the euthyroids is 29% or 30% in round numbers. There is a spread of 5 to 65%. We are not absolutely certain that all of these individuals were euthyroid and some of the spread may be due to errors in the clinical estimation of thyroid function. The patients with exophthalmic goiter had a mean uptake of 75%, the spread being from 35% to 95%. There is some overlap of these two curves, but it is not too bad. By and large the distinction between euthyroidism and hyperthyroidism due to exophthalmic goiter is fairly sharp.

Figure 3 is a similar representation of the urinary output of I^{131} following a tracer dose.

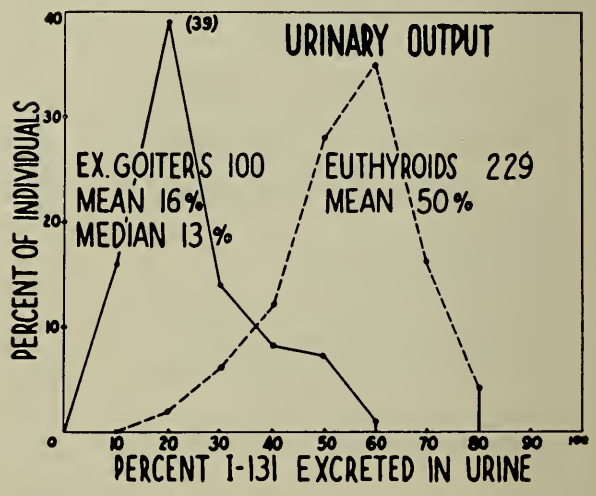


Figure 3

The findings are reversed. The euthyroid individuals excrete 50%, the hyperthyroid patients only 16%. There is a larger overlap, probably due to errors in the collection of the urine.

A third diagnostic approach involves the determination of total plasma I^{131} and protein bound I^{131}. Twenty-four hours after administering a dose of I^{131} a certain amount of the I^{131} will have been converted to a protein bound hormonal iodine and a certain amount will be contained in the plasma as inorganic iodine. In hyperthyroidism the amount of protein bound iodine will be high and the ratio of protein bound

to total plasma iodine will also be high. This "conversion ratio" is probably a more accurate means of distinguishing between thyroid states than is thyroid uptake or urinary excretion, but the technical difficulties especially with small tracer doses have been too great to justify the labor involved. At present, however, with a well-type scintillation counter the technical problem is much simplified and the determination of protein bound I^{131} may be more practical.

Table I

THE TRACER DOSE OF I^{131} IN THYROID DISEASE

	Thyroid pickup, %	Urinary output, %
Euthyroid	29	50
Exophthalmic Goiter	75	16
Recurrent exoph. goiter	59	27
Toxic nodular goiter	51	29

Table 1 is a resume of thyroid uptake and urinary output of a tracer dose in the four categories as indicated. You will note that the thyroid uptake is highest in toxic diffuse goiter, less in recurrent toxic diffuse goiter, and still less in toxic nodular goiter. The urinary output is the reverse. The tracer study is still of some significance in the diagnosis of recurrent toxic diffuse goiter, but it is not so useful in toxic nodular goiter. There are patients with severe toxic nodular goiter who have a normal tracer study. Indeed, there are enough of them so that confidence in the test in this group of patients should not be too great. The basal metabolic rate is a more accurate index of hyperthyroidism in toxic nodular goiter. There are other errors in the tracer dose as a diagnostic procedure. If the patient is taking iodine in any form the test is useless. The same holds true for medication with desiccated thyroid or any of the antithyroid drugs. Some of the vitamin mixtures contain iodine and if enough is ingested they will also interfere. Yet while the test may not indicate the degree of hyperthyroidism it might provide diagnostic help where the basal metabolic rate fails. If a patient presents herself with exophthalmos, a loss of weight, tremor, rapid heart and a goiter, one would easily recognize the fact that the patient has an exophthalmic goiter. A basal metabolic rate will merely verify the fact that you are not stupid but it does indicate the degree of the toxicity which is present. Most of the patients with a toxic diffuse goiter do not require laboratory aid for a diagnosis. Let us suppose we have a patient with a nodular goiter plus questionable symptoms of hyperthyroidism. The basal metabolic rate will be more useful in diagnosis than the tracer dose, but as long as the patient has a nodular goiter the odds are that it should be removed on general principles. But suppose we have a woman of 45 years of age, who has a blood pressure of 185/90, a tachycardia, nervousness, some shortness of breath, some heat intolerance, no enlargement of the thyroid gland and a basal metabolic rate of +25%. If she has hyperthyroidism it would be due to a toxic diffuse goiter and not to a toxic nodular goiter. In this circumstance the test will usually settle the problem. Nervousness has no effect upon it nor does hypertension, both of which have a tendency to elevate the basal metabolic rate. Thus, where you truly need a diagnostic test it is probably better than the basal metabolic rate.

In addition, a tracer study is absolutely necessary before therapy with I^{131}. There are innumerable applications in clinical research and its use is imperative in a teaching institution.

Dr. James A. Schoenberger, Assistant Professor of Medicine: I think the answer to the question "Is the BMR obsolete?" would depend upon whether we had a better test to replace it. Radioactive isotopes are extremely useful, but they are not going to be generally available in smaller communities for a long time. Until isotopes are available everywhere we will have to continue to use the basal metabolic rate. There is an additional test of thyroid activity, namely the chemical determination of protein bound iodine. I have been told that the method of determination is becoming relatively simple. I would like to ask Dr. Seed to evaluate this additional test.

Dr. Lindon Seed: Some people believe that the determination of protein bound iodine is of more diagnostic value than the basal metabolic rate. The chemical analysis is not an easy one,

nor does it seem easy to learn. Confidence in the examination depends upon confidence in the technician. When Dr. George Curtis was at the University of Chicago the determination of the PBI was an important diagnostic test, but when he left for the University of Ohio at Columbus he apparently took the art of the technique of the PBI along with him. In a similar manner Dr. Paul Starr at Los Angeles has established a sound technique for its determination. In these two places it is a very reliable criterion. As far as I know there is only one private laboratory in the city which will do a PBI with any degree of accuracy. The chemical analysis has been simplified but apparently not enough for the ordinary laboratory even in the large hospitals to deliver reliable reports.

Dr. Schoenberger: Does any laboratory error creep into the PBI, or do drugs affect it?

Dr. Lindon Seed: Yes, it does. If a patient has had an x-ray of the gall bladder the PBI is elevated for five or six months. If he has had a sinus tract injected with lipiodol the test is unreliable for about fifty years. Also meticulous care must be taken in the laboratory to see that no trace of iodine ever enters it. The gall bladder dye interferes with thyroid uptake of I^{131} for only a few days to a week, diodrast for one to two weeks, lipiodol for much longer. The effect of iodine depends somewhat upon the type of patient. If a patient receiving Lugol's solution has a toxic diffuse or exophthalmic goiter and the medication is discontinued, the thyroid gland will recover its ability to trap iodine in one week. If the patient has a toxic modular goiter it may be many weeks or even months. However, the inhibitory effect of the anti-thyroid drugs wears off in twenty-four hours. Indeed there may be a secondary increase in uptake so it is advisable to wait a few days after anti-thyroid therapy has been discontinued before attempting a tracer study with I^{131}.

Dr. Melvin Chertack: How effective are BMR and I^{131} in the diagnosis of hypothyroidism? We have studied a significant number of patients who complained of chronic fatigue at the University Health Service. Most of the patients responded well to the administration of thyroid in spite of the fact that only one individual within this group of more than thirty subjects had a low I^{131} uptake. In fact, we observed a girl who suffered from a clinically manifest myxedema with marked changes in BMR and serum cholesterol but without any significant alteration of the I^{131} uptake. In this last case the BMR certainly was superior to the radioactive tracers in establishing the diagnosis. One wonders whether our classification of thyroid disease of those with hypofunction and those with hyperfunction is not too simple; whether there might be a dysfunction of the thyroid gland which might cause a normal I^{131} uptake but a clinical hypothyroidism, perhaps through the production of an abnormal thyroid hormone or through an abnormal utilization of thyroid hormone in the tissue.

Dr. Lindon Seed: My experience in hypothyroidism and the tracer dose of I^{131} is not great. The tracer dose is not of much use in the diagnosis of hypothyroidism. There is always a very low uptake in thyroid deficiency, but there are also some very low uptakes in euthyroid individuals. I do not believe there is such a thing as hypothyroidism with a normal thyroid uptake of I^{131}. A dysfunction of the thyroid gland other than simple hypersecretion and hyposecretion has been postulated in exophthalmic goiter. It has never been proven. A dysfunction in the presence of hypothyroidism is a no less reasonable theoretical assumption. The basal metabolic rate seems to me to be a fairly reliable index of hypothyroidism.

Dr. Robert Grissom, Assistant Professor of Medicine: What is your opinion about the value of determining PBI-131, a technique now used at Presbyterian Hospital?

Dr. Lindon Seed: We made hundreds of PBI-131 determinations but they require a fairly large tracer dose. Even with a flow gas counter a 100 uc. tracer dose is necessary for technical accuracy and we have now reduced our tracer dose to 20 uc. With the advent of the well-type scintillation counter accuracy is much improved. The flow gas counter, counting beta rays, does not give reliably reproducible results. The well-type scintillation counter in which a test tube containing the liquid to be checked is dropped into the center of a crystal counts only gamma rays. It is very accurate and results are always reproducible. Five cubic

centimeters of blood or plasma can be checked instead of one and the efficiency of about 30 to 40% permits counting up to 40% of all disintegrations.

Dr. James Schoenberger: Dr. Grissom and I found nobody at Oak Ridge who was enthusiastic about the scintillation counter.

Dr. Lindon Seed: That is because they do not have the proper type of scintillation counter.

A Physician: What do they cost?

Dr. Lindon Seed: An end window type costs about $4000.00 and the well type $850.00.

Dr. James Schoenberger: What is your background count?

Dr. Lindon Seed: Less than 60 counts a minute for the end window variety and 200 a minute for the well type counter.

Dr. James Schoenberger: Do you use the usual photomultiplier tube?

Dr. Lindon Seed: Yes. Apparently one of the tricks in the circuit is the choice of the right photomultiplier. The technical details I do not understand but I do know that the scintillation counter is now a marvelous instrument.

Dr. Ford K. Hick, Professor of Medicine: How can you look over a BMR tracing and tell whether it is good or not?

Dr. Lindon Seed: You begin by looking upon the test as one which may be erroneous all the time. In my office I insist that the technician take the resting pulse rate and blood pressure. This data is very useful. A patient with an elevated BMR has an elevated pulse rate. It is possible to have an elevated BMR with a pulse rate of let us say 80 per minute, but only if there is an associated high pulse pressure—a blood pressure for instance of 160/60. A high pulse rate accompanied by a high pulse pressure is the normal finding with a high BMR. The conditions under which the BMR is performed are presumably basal and this is the time to determine pulse rate and blood pressure. A perusal of the chart is helpful. It records the respirations over a period of time. The drop in oxygen consumption is determined by drawing a line connecting the points representing the end of expiration. If the points do not fall on a straight line there is something wrong. Frequent, extra large respiratory swings make it difficult to lay down a straight line. If the line cuts off too many respiratory excursions throw the chart away. There also must not be any variations in the rate of consumption or deviations from a straight line. If there is a slow steady leak in the hookup I do not know how to recognize it on the graphic record. Be suspicious of an unusual finding in a patient with both upper and lower plates of false teeth. The mouthpiece frequently does not fit. If the respiratory excursions increase in rate and amplitude as the test progresses one can be reasonably sure that the soda lime is not absorbing the CO_2. This is, practically speaking, the only error which gives an abnormally low reading; all other errors tend to elevate it.

Dr. Ford Hick: Is not obesity another possible cause of error?

Dr. Lindon Seed: Obesity throws the calculations off. A BMR is a comparison of the heat production of an individual taken at complete physical and mental repose and compared to the average heat production according to age, weight, height and sex. It is a comparison to a biological average and as such cannot be absolutely accurate in each specific comparison. An obese individual does not conform to the average and the calculation may be in error. This is also true of the very young, the very old, the very thin, and the very unusual person.

Discography in the Diagnosis of Herniation of the Lower Lumbar Intervertebral Discs

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The diagnosis and localization of posterior herniation of the nucleus pulposus remains an important problem, despite better understanding of the clinical syndromes of "sciatica" and "lumbago"[1,2,3] and the more general use of special diagnostic tools such as the myelogram[4,5]. Myelography has been very strongly recommended by some[6]; others have found it to be useful only when minor deformities are considered in conjunction with clinical findings[4]; and a few, such as Dandy, have recommended that diagnoses be based entirely on history and physical findings[7]. It is not surprising, therefore, that "back" cases comprise an important problem group in many clinics. It should be emphasized that a positive diagnosis does not determine treatment, since many cases are substantially self-limited, but it is a most helpful adjunct to treatment and a virtual necessity in compensation or court cases.

Recently disc puncture has been reported as an important diagnostic procedure. A saline solution may be introduced into an intervertebral disc through a spinal needle. If the disc is normal, only a small amount of solution can be injected and there is no pain. If the disc is herniated, larger volumes may often be introduced and the patient's clinical picture of nerve root pressure may be duplicated, allowing diagnosis of rupture and its localization, according to Hoen, Druckmiller and Cook[8]. By using a radiopaque medium not only may the patient's pain be duplicated, but the herniation can be seen in an x-ray. In addition, use of this technique, which may be called discography or nucleography, allows recognition of asymptomatic disc degenerations and ruptures. A method of discography utilizing puncture of the disc in the midline posteriorly was described by Lindblom of Sweden in 1948[9] and he has subsequently reported additional experiences[10,11]. This technique may be used for the three lower lumbar spaces and our work is based on its use. It will not serve above this level, however, because of danger of injury to the cord. Erlacher of Germany has independently developed a method utilizing a postero-lateral disc puncture in which the needle does not enter the subarachnoid space[12,13]. This procedure may be performed at any level, including the cervical region, but is probably somewhat more difficult than Lindblom's method.

Discography has not gained recognition in the American literature despite many obvious advantages. We believe it to be a technique of greater value than myelography in the management of ruptured intervertebral discs and feel that our small series merits a report.

MATERIAL AND METHODS

Equipment:* One set of paired spinal needles is used for each disc, and we have generally examined the three lower lumbar discs. A two-inch 21-gauge needle is employed as a guide and inserted as far as but not generally into the dural sac. Through this is passed a three and one-half inch 26-gauge needle, since it is not rigid enough to be directed without a guide. After proper positioning, this needle is directed transdurally into the disc.

Injection is carried out with a one cubic centimeter Luer-Lok tuberculin syringe. A plain tuberculin syringe may be used but frequently is pushed out of the needle hub from the pressure of the injection, spraying contrast medium and jarring the patient. Syringes with a plunger of larger diameter give a poor mechanical advantage. They are extremely difficult and sometimes impossible to use. We have com-

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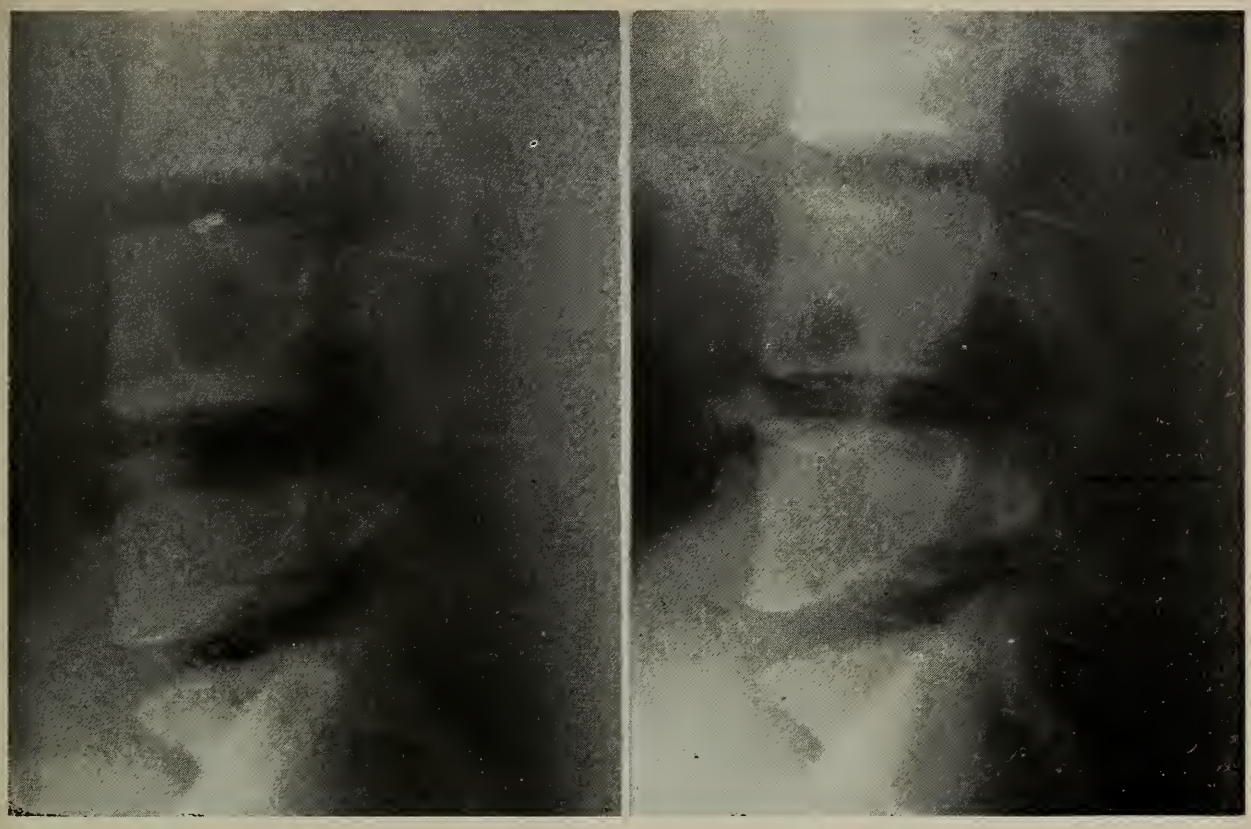


Figure 1.—Lateral x-ray films to show the positioning of the two inch guide needles and the three and one-half inch disc needles. *A.* The two lower guide needles are in good position while the top one is aimed a little below the interspace. It can be repositioned without taking an additional film. *B.* The disc needles have been passed through the guides into the discs.

monly employed 70 percent Diodrast as a radiopaque medium.

Procedure: The patient is premedicated with 15 mgm. morphine sulfate but need not be in a fasting state. He is placed in the lateral spinal position with his back flexed. Others have used a knee chest position but this is less comfortable for the patient and offers no obvious advantage. After suitable aseptic preparation, the 21-gauge guide needles are inserted in the midline of the three lower lumbar interspaces, approximately to the epidural space. The preliminary direction is almost perpendicular to the skin. A lateral x-ray is taken and necessary modifications in direction are made so that each needle will point squarely to its corresponding disc space (Figure 1a). This repositioning is frequently done blindly without further check films. The use of the fluoroscope for positioning has not proved satisfactory in our hands. The 26-gauge disc needles are now inserted transdurally. The posterior longitudinal ligament overlying the disc causes a rather marked resistance and then passage through the disc for about one-half inch or slightly more is almost without resistance (Figure 1b). If bone is encountered and the disc space cannot be entered, or if the patient has a nerve root paresthesia, the guide needle must generally be repositioned. When all the needles are thought to be properly located, a final check film is taken. If this is satisfactory, approximately one and one-half cubic centimeter of 70 percent Diodrast is injected into each disc, those least likely to be ruptured being injected first. This is important, since injection of a ruptured disc causes pain, and may make it difficult to tell if following injections are painful. On completion of injections, a lateral film is taken and if this shows all interspaces injected, the needles are withdrawn and an antero-posterior film is taken. When desired, obliques and stereo films are obtained. Patients are kept in bed for at least a few hours. They may require medication for pain for as long as 24 hours and occasionally for post-lumbar puncture headache.

It has been our practice to test the pressure and dynamics and collect a sample of spinal

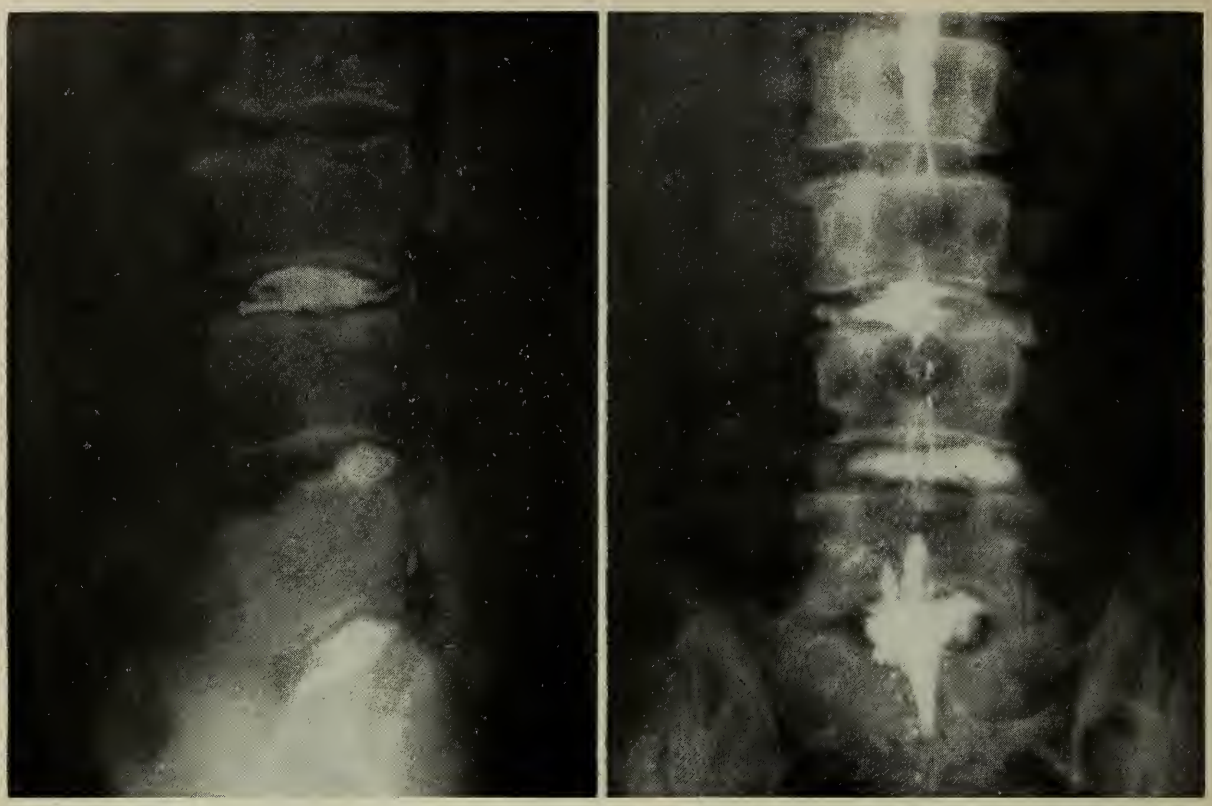


Figure 2.—Discograms in Case 2. *A.* Lateral film. The third lumbar disc shows a definite posterior bulge or incomplete herniation. Injection resulted in duplication of the patient's symptoms. The fourth and fifth discs are not herniated, although somewhat abnormal. The patient experienced no pain on injection of these. *B.* Anteroposterior film. The herniation of the third disc is seen to extend beyond the vertebral border on the left, indicating a posterolateral herniation. This coincided with the symptoms and was confirmed at operation.

fluid while waiting for the first check film. This is obviously not an integral part of the disc examination per se but offers advantages in the patient's general work-up[6].

Interpretation: We concur with Lindblom[10,11] that two factors are necessary for the diagnosis of a ruptured disc by this technique. First, injection should reproduce the patient's symptoms of nerve root pressure. Secondly, the lateral x-ray should show a posterior extension of dye. A positive x-ray may show a bulge of opaque material posteriorly (Figure 2a, 3a) or a leak of dye into the epidural or perineural spaces. In the cases with a bulging disc but an intact posterior longitudinal ligament the injection is usually extremely painful and often only one-half cubic centimeter of Diodrast can be injected (Figure 3a). The injection of these as well as normal discs requires considerable force[8,10]. With complete rupture of the posterior longitudinal ligament there is less pain on injection of the disc and little or so resistance is felt. The -ray of these cases shows opaque material in the epidural spaces (Figure 4a). The antero-posterior x-ray will often show lateralization of the disc rupture to the affected side (Figure 2b). In the normal disc the x-ray frequently shows a rather characteristic double mushroom (Figure 5a). The dye is thought to outline the surface of the nucleus pulposus rather than to diffuse throughout it[10]. In the degenerated but unruptured disc the Diodrast may diffuse throughout the degenerated disc material and on x-ray be represented as a structureless shadow or by numerous thin layers (Figure 4b). Occasionally we have found ruptures of the disc laterally or anteriorly. These cases are read as negative with respect to nerve root irritation. An interesting sidelight has turned up in regard to Schmorl's nodes. In some cases with an apparent Schmorl's node the discogram shows no herniation of disc material into the body of the vertebra. In other cases, however, where the plain x-ray appears normal, the discogram shows a herniation of

material into the vertebral body. These also are thought to be non-symptomatic ruptures.

RESULTS

The results of 28 discogram attempts in 23 patients are shown in Table 1. In one case, as a result of obesity of the patient, the needles were too short and barely reached the spinal canal. We are now experimenting with longer needles to overcome this difficulty. In five patients the results were unsatisfactory in one or two interspaces. In all of these a repeat examination was satisfactory. A total of 30 ruptured discs were found in 20 patients and two patients showed no evidence of disc rupture. The locations of the ruptured discs are shown in Table 1.

Of the 20 patients shown to have ruptured discs, 12 were treated by exploration of two or more interspaces with excision of any grossly abnormal discs, and eight were treated conservatively without operation. In every case coming to operation the surgical findings coincided with discography for both normal and ruptured discs (Table 2). One case with a negative discogram diagnosed as chronic sacroiliac and lumbosacral strain was later operated on elsewhere. The surgeon explored the three lower lumbar spaces, found all discs to be normal and performed a lumbosacral fusion (Case 1).

TABLE 1

28 discograms in 23 patients —

20 Patients with ruptured discs		Totals	
L5	7	L5	15
L4	3	L4	12
L3	1	L3	3
L4 and L5	7		
L3 and L4	1		
L3, L4 and L5	1		

5 discograms requiring partial repetition
2 patients with unruptured discs
1 failure due to obesity

TABLE 2

Operative findings in 12 cases

Location ruptured discs		Negative explorations	
L5	5	L5	2
L4	2	L4	6
L3	1	L3	1
L4 and L5	4		
Total	16	Total	9

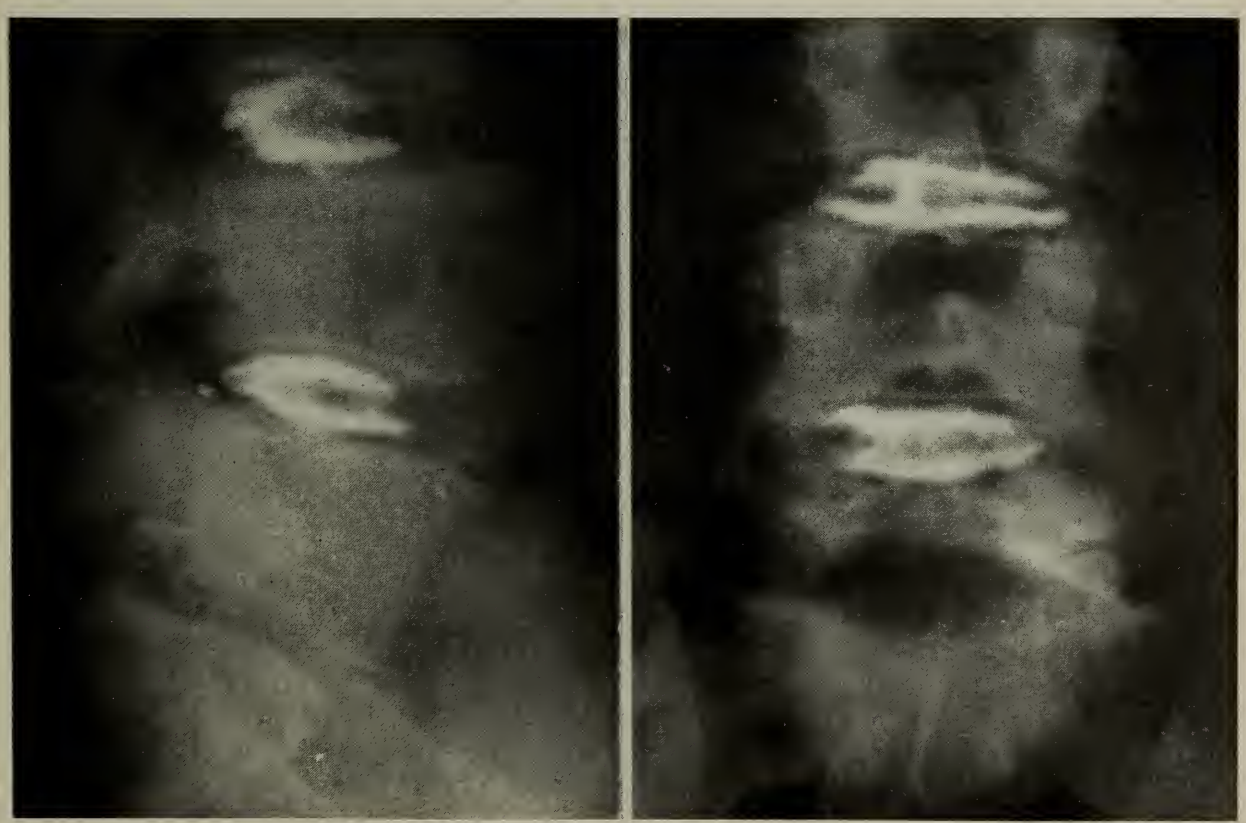


Figure 3.—Discograms in Case 3. *A.* Lateral film. The third and fourth discs are well outlined and show a normal central location and bifid form. The injection of but 0.5 cc of 70 percent Diodrast in the fifth interspace caused a severe exacerbation of the left sciatic pain and a large incomplete herniation may be seen. *B.* The anteroposterior film fails to reveal dye in the fifth interspace because so little could be injected.

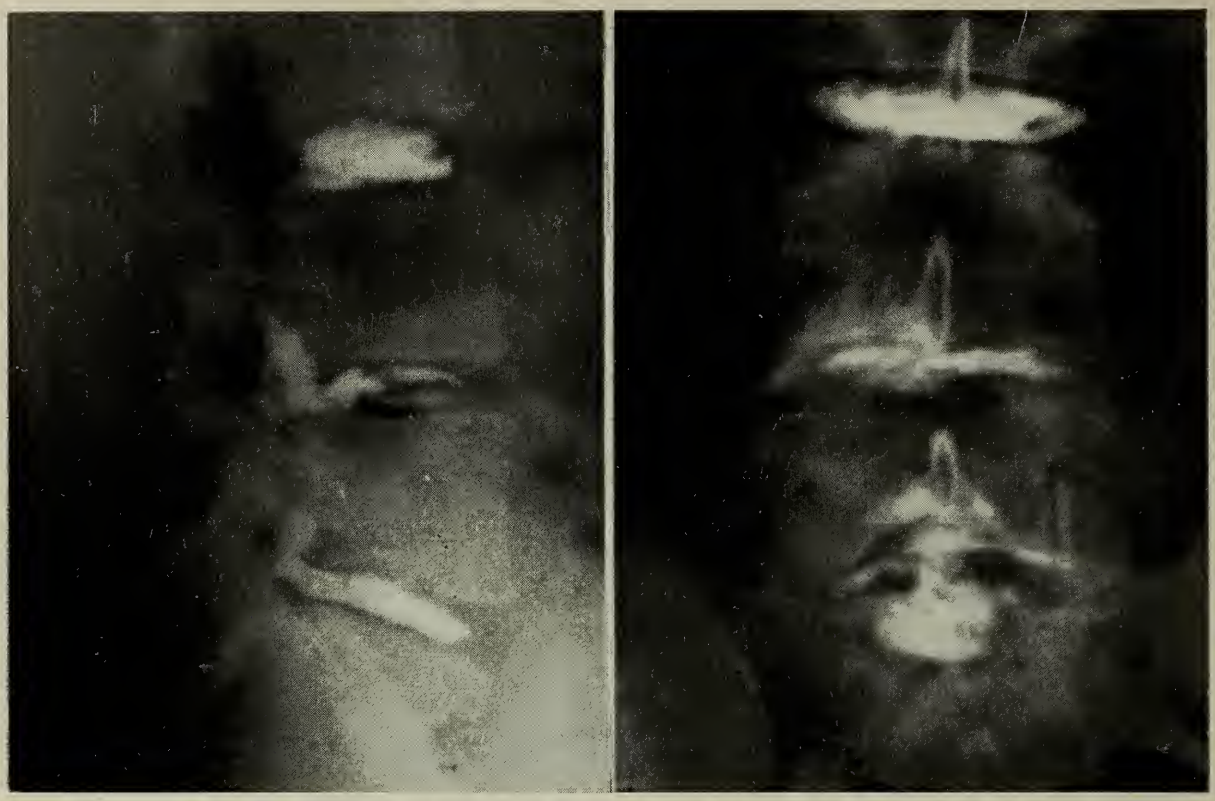


Figure 4.—20-year-old male with a history of back trauma and recurrent right sciatic pain. *A.* Lateral film. There is complete rupture of the two lower lumbar discs with epidural spread of Diodrast. That the dye does not follow the path of the needle puncture is seen in the fifth interspace. There was much less pain on injection than in Cases 2 and 3 and there was relatively little resistance to the introduction of the dye. The third disc is degenerate. *B.* Anteroposterior film. There is definite lateralization to the right in the fourth interspace, the side of the symptoms. This occurs much too frequently to be a coincidence.

Four patients with positive discograms had previously had myelography. In one case the myelogram and discogram both indicated rupture of the fourth lumbar disc. In two cases the myelograms were negative while discograms revealed a rupture which was confirmed at operation. The fourth case was reported to have a tumor at L3 on the basis of myelography. The discography indicated rupture of L5. This was confirmed at operation and no lession was found at L3.

There have been no complications of a serious nature. Patients experience exacerbation of symptoms for a few hours when ruptured discs are present and on occasion spinal headaches result.

Case 1.—W. L. H., a 43-year-old merchant seaman, was admitted with a chief complaint of low back pain with radiation down the posterior aspect of the left thigh into the lateral aspect of the calf and foot of eight months duration. At the onset of pain the patient was heaving on a mooring line when he twisted his back. One month later he attempted to lift a hatch cover, which markedly aggravated his pain. Subsequently the patient was unable to work. He was examined and treated by four different doctors, all of whom told him he had a ruptured disc. Being a seaman, he came to us seeking surgery.

On admission, positive physical findings were limited to the back. The patient stood with normal physiological curves of the spine. Spinal flexion was limited to 60° because of pain. Sacrospinalis spasm was marked bilaterally with tenderness elicited in both sacral triangles. Knee and ankle jerks were normal. Sensory examination revealed equivocal areas of numbness on the lateral aspect of the left foot, medial aspect of the right foot, and lateral aspect of right calf. There was no atrophy of the buttocks or lower extremities. Straight leg raising was painful at 50° bilaterally, as was combined leg raising, the pain being confined to the lumbosacral region without radiation. Body torsion, Patrick's and Gaenslen's tests were all positive for bilateral sacroiliac pathology. X-rays of the lumbosacral spine were within normal limits.

Initially the patient was treated with local injections of the sacroiliac joints, which treatment provided marked relief of symptoms for periods up to six hours. Further improvement resulted from treatment with local heat and massage to the lumbosacral region, postural exercises, and administration of tolserol. Since

he had been previously diagnosed as having a herniated disc, a routine discogram was carried out. It was our impression prior to this examination that the patient had a moderately severe sacroiliac and lumbosacral strain. Normal discs were demonstrated at the fourth and fifth lumbar interspaces by x-ray (Figure 5), and by absence of symptoms at the time of injection. The patient was fitted with a back brace and sent home for one month. It was later learned that the patient had had an exploration of the three lower lumbar interspaces elsewhere. No disc abnormalities were found and a lumbosacral fusion was done.

This case illustrates the ability of discography reasonably to exclude herniated intervertebral disc as a cause of back and leg pain in a patient, despite previous diagnoses of this condition. We do not believe that this is possible with myelography.

Case 2.—A. H. N., a 40-year-old male veteran, was admitted with a complaint of pain in the lower back and left leg of four weeks duration. Eight years before the patient sustained his initial back injury as a paratrooper. Since that time he had had periodic backaches relieved by a few days of rest. One month before admission the patient twisted his back playing handball. During the next five days the back pain got worse and he noted radiation into the posterolateral area of the left buttock and thigh as well as into the left groin and down the medial aspect of the thigh to the knee and occasionally into the left testicle. The patient went to a private neurosurgeon who performed a myelogram which was reported as negative. For financial reasons the patient then sought government medical care.

On his admission the essential findings were limited to the back and lower extremities. The lumbar spine was flat with marked spasm of the erector spinae masses bilaterally. There was tenderness at the level of the fourth lumbar interspace with pain radiating in the sciatic and obturator distributions on percussion. Straight leg raising was possible on the left to 90° without much discomfort. The left knee jerk was much less active than the right. The ankle jerks were equal. There was an area of anesthesia over the upper medial aspect of the left thigh. X-rays of the spine showed several old compression fractures in the thoracic region and rather marked traumatic arthritis of the lumbar spine.

The patient was treated with Williams' position and local heat without relief. Discography of the three lower lumbar spaces was carried out. Injection of the third lumbar disc caused pain in the posterolateral aspect of the left buttock and thigh and pain in the left groin radiating down the medial aspect of the thigh to the knee. X-rays revealed posterior bulging of the disc in this interspace (Figure 2). The third and fourth lumbar interspaces were explored and a ruptured disc removed from the third interspace.

This patient presented a somewhat atypical picture of mid or upper lumbar nerve root irritation manifested

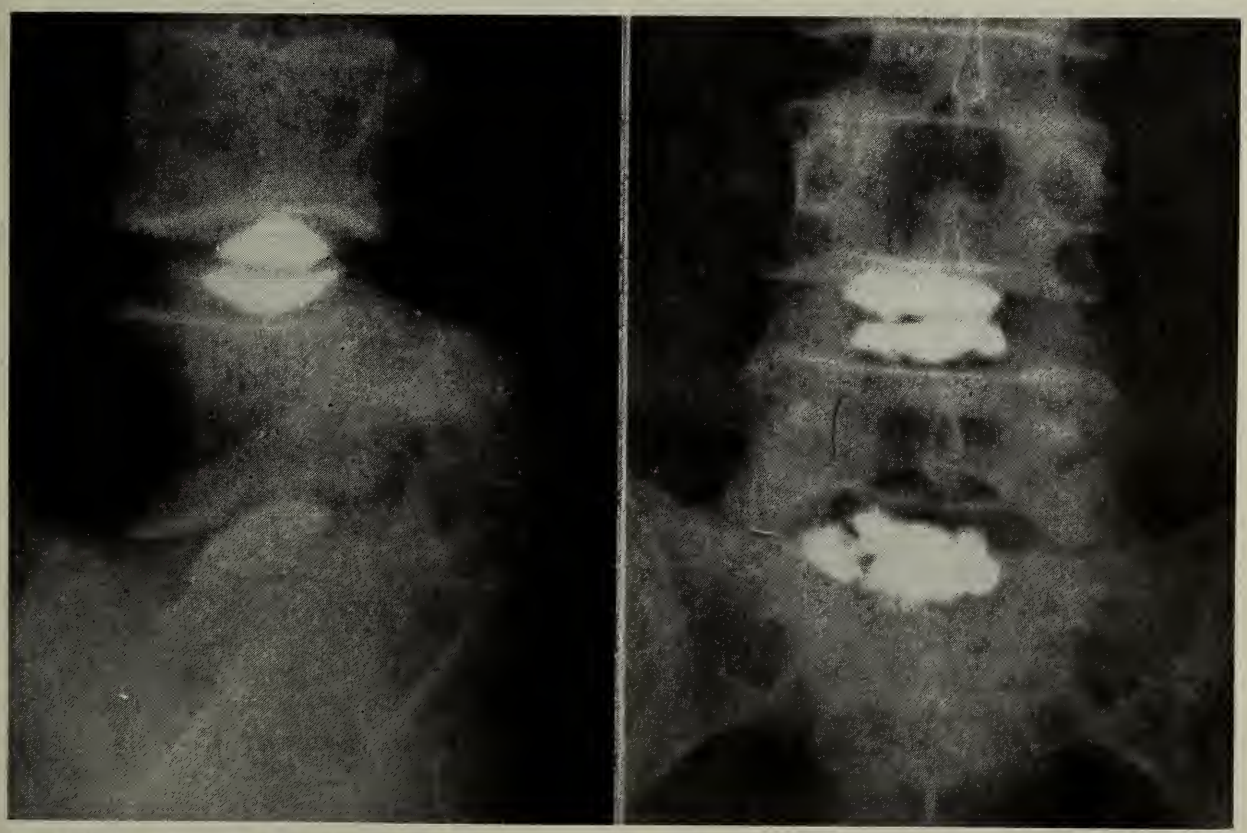


Figure 5.—Case 1. The patient clinically had a back strain but had been told he had a "disc" by several other doctors. The discogram showed normal fourth and fifth lumbar discs. *A.* Lateral film. Discs are centrally located and the fourth one has the characteristic normal bifid form. *B.* Anteroposterior film.

by both sciatic and obturator pain. He rightly received a myelogram which ruled out a cord lesion as the cause of the symptoms, although it failed to disclose the herniated disc. The discogram then clearly demonstrated the rupture. It was in one of the less usual positions and would not have been found in routine exploration of the two lowest lumbar spaces. We feel that this is a good example of the complementary value of myelography and discography in the complicated case.

Case 3.—J. G. H., a 33-year-old national guardsman, was admitted for severe pain in the back and down the posterolateral aspect of the left leg of two days duration following a rough ride in an army truck.

On admission positive findings were limited to the orthopedic examination. The patient was most comfortable on his side with his knees drawn up and was unable to stand because of pain. The left ankle jerk was absent and the knee jerk diminished. Straight leg raising to 30° on the left caused lancinating pain in the sciatic distribution. There was loss of pain sensation over the left lateral calf and foot. The dorsiflexors of the left ankle were very weak but there was no muscular atrophy. X-rays of the lumbosacral spine were unremarkable.

The patient was treated with bilateral Buck's extension, radiant heat and rapid sinusoidal stimulation of the lower back muscles with considerable relief of symptoms. A discogram revealed rupture of the fifth lumbar disc (Fig. 3). Since the patient showed rapid subsidence of symptoms with return of his ankle jerk and increase in strength of his dorsiflexors, it was elected to treat him conservatively. He was discharged asymptomatic with a back brace in two months. One month later he returned to work.

This case emphasizes the tendency of many ruptured intervertebral discs to have self-limited symptoms. The diagnosis was possible on the basis of the rather classical symptoms and findings and the discogram was made primarily to localize the pathologic disc should exploration become necessary.

DISCUSSION

The earlier literature contains reports of disc ruptures supposedly due to lumbar punctures, and this had deterred a good many from using discography. In most of these cases, however, there was an infectious element and the pathologic picture was one of disc herniation into a partially destroyed vertebral body[14,15]. These were not herniations from the needle punctures and their occurrence would seem to have little bearing on the possible complications of discography. Virgin has shown that the annulus may be incised with a knife and the spine then subjected to compressions up to 500 lbs. without herniation of nuclear material[16]. This confirms the earlier work of Friberg, who demonstrated in cadavers that defects up to 4.7 mm. in diameter could be made without subsequent rupture of the disc[17]. In all of our operated cases at least one normal space was explored to verify our findings on discogram. Regardless of whether the disc was pathological or not, no evidence of needle puncture was found and no nuclear leak was seen. Hoen, Druckmiller, and Cook used a 20 gauge instead of a 26 gauge needle and reported no ill effects in 16 cases[8].

For the diagnosis of space-displacing lesions in the spinal canal such as nerve root or spinal cord tumors myelography should be used. In the verification and localization of disc pathology it is our feeling, however, that discography is more direct and far superior to myelography, which is an indirect method. The accuracy of myelography in the diagnosis of herniated disc is reported to be in the order of 60 to 90 percent[4]. In our small series the operative findings have coincided with the discogram in all cases. We do not believe that this series has statistical validity but feel that the accuracy of discography should exceed that of myelography. Although the interpretation of the discogram is relatively simple, technically it is more difficult to perform than the myelogram. In order for the surgeon to insert the 26 gauge needle into the center of the disc, the needle must pierce the posterior longitudinal ligament at almost a 90° angle, and this is not the easiest direction to enter the subarachnoid space. With the present technique, the Diodrast is absorbed within thirty-six hours, leaving no trace. In contrast, in myelography using radiopaque oil there is always some residual material left in the dural sac and there is always the possibility of nerve root irritation due to the presence of a foreign material.

In our hospital a large proportion of the back patients are compensation cases. Frequently they have had numerous examinations elsewhere and a diagnosis of a herniated disc has often been made. Even though our physical findings may not substantiate the diagnosis, the burden of proof rests on us. The discogram has been an invaluable aid in these cases, and we have felt more secure in the opinions that we have rendered. The treatment, however, should not be determined by the result of the discograms but by the clinical course of the pa-

tient (Case 3). It is noteworthy that prior to Mixter and Barr's paper in 1934[1] disc cases healed without operation, as they have for the last thousand years. The mere presence of a ruptured disc is not an indication for surgery.

SUMMARY

Following insertion of a fine lumbar puncture needle through the posterior annulus fibrosus in any of the three lower lumbar spaces, an absorbable contrast medium may be injected to outline the nucleus pulposus. This procedure is called discography and makes possible the demonstration of various types of disc pathology, especially herniation. The technique is presented with representative cases. We believe that discography is a valuable adjunct in the diagnosis of ruptured intervertebral disc and probably more accurate than myelography in the verification and localization of disc herniations.

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FAMILY HEALTH

Medical educators and administrators are concerned with the various pressures that influence the pattern of medical care. In the medical school this has increased the study of social, emotional, cultural, and environmental factors that may be associated with illness situations. The medical student of today — the physician of tomorrow — is participating in an educational program that is devoting increasing attention to the meaning of illness to the individual and the family. The doctor is developing awareness of his duty to prevent disease and maintain health as well as to restore his patient to an integrated and maximal productive capacity in society. Hospitals are making a pronounced effort to anticipate some of the implications of the burden of disease and to reconsider the nature of their contribution to the health of the community. *Henry J. Bakst, M.D., A Co-ordinated Approach To Family Health. Boston Med. Quar., March 1953.*

The Use of Reichstein's Substance "S" in the Treatment of Cancer

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During the past year we treated 20 patients suffering from inoperable breast cancer by injections of Reichstein's Substance "S", (17 hydroxy-11-desoxy-corticosterone), a substance differing from cortisone only in the absence of double-bonded oxygen at position 11. We here report the effects of this hormone in the alleviation of the distress, disability, and discouragement common to patients with hopeless metastatic cancer.

The patients were all hospitalized. Two were bedfast and have remained so since; the others remained ambulatory with the exception of short terminal periods in the eight who died while under treatment. The diagnosis was proved in each case by biopsy. In those who had original red blood sedimentation rates (Westergren) above 40 mm. per hour, drops into the 20's occurred only after one or two weeks of therapy. The hormone was given by intramuscular injection of an aqueous suspension. While hospitalized the patients received 25 mg. daily; at home they received 50 mg. three times a week.

Seven of the eight patients who died while under treatment received medication for less than three months: one survived five months from the commencement of therapy. None of this group showed objective improvement, but five were considered to have derived subjective benefit as demonstrated by a decreased need for analgesics and opiates and increased appetite and sense of well-being. Twelve patients were alive at the conclusion of the study, after periods of treatment ranging from four to nine months, with total dosages of Substance "S" varying from 2,750 to 5,700 milligrams. All felt much better while getting injections, and became worse within a month after stopping treatment. The majority maintained weight or made slight gains. No marked rises in hemoglobin titer or red cell counts were noted. Several sloughing ulcerations became cleaner but none healed. We did not observe the disappearance of any masses or calcification of bony metastasis, or histologic changes in the tumors as studied by repeated biopsies. In spite of varying degrees of pain relief, improved appetite and improved hopefulness, the course of the disease was progressively downhill in six patients; in three, the disease has been static for periods up to five months. Four patients not only felt better but appeared much improved and reports of their cases follow:

Case 1. Mrs. H.R., age 49, white female. Found lump in breast August, 1947. Radical resection October, 1947, followed by numerous x-ray treatments. In December, 1950, we first noted multiple, subcutaneous nodules on chest wall near scar; biopsy showed carcinoma. In May, 1951, there were multiple lymph node metastases. On May 9, 1951, she began receiving 50 mg. of Substance "S" three times a week. Within two weeks she reported improvement in appetite and in the sense of well-being. Medication was continued until August 15, 1951, at which time a retro-retinal mass had disappeared and pulmonary lesions were apparently stationary but there was a slight but slow increase in the number of skin nodules on the chest. There was no histologic change in the skin nodules. The patient thinks her strength has failed slightly since discontinuing Substance "S" and several new skin nodules have appeared. The remarkable feature of this case is the disappearance of the retro-retinal nodule, which unfortunately was not biopsied.

Case 2. Mrs. L.E., age 53, white female. Found lump in breast in June, 1943, but had no treatment until a radical mastectomy in December, 1947. No evidence of remote metastasis was discovered until she returned to the clinic October 20, 1950, complaining of swelling in the left side of her neck, severe and extensive backache, and inability to turn her head to the left. There was a massive involvement of the left supraclavicular and cervical lymph nodes with woody infiltration of the left trapezius muscle. X-Ray survey showed widespread involvement of the thoracolumbar spine. She received a total of 5,650 milligrams of Substance "S" between November 9, 1950 and August 15, 1951. Her backache was lessened markedly within

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two weeks of treatment, and she has not resumed the use of analgesics. There was slow, slight decrease in the size and firmness of the mass in the left side of the neck, with increasing ability to turn the head to the left. Her weight has remained constant. Pain in the neck and back continued less than when treatment was begun, but notes a decrease in energy and ability to work since its discontinuance. Repeated x-ray studies and biopsies show no change in the state of lesions in bones and lymph nodes.

Case 3. Mrs. R.T., age 46, white female. Four months after discovering a "lump" in her right breast in 1944, the breast was removed followed by a couple of x-ray treatments. She first came under our care in 1948, with extensive osteolytic metastasis in the thoraco-lumbar vertebrae and with a pathologic fracture of the tenth thoracic vertebra causing a slight kyphosis. Pain was greatly relieved by testosterone, and some recalcification of one vertebra was observed. She remained fairly comfortable for a time with the help of a spinal brace. In May, 1950, the x-ray shadow of the tenth thoracic vertebra was gone, and the patient complained of much pain on trying to wear the brace. Shortly thereafter sharper angular kyphosis appeared with increasing weakness, uselessness of the legs, and inability to stand or walk. Testosterone was continued, but 20 months after its inception she was completely bedfast and unable to move from the supine position in bed. A slightly fixed lymph node in the right axilla, 2 cm. in diameter, was positive for carcinoma. She was started on Substance "S" on December 15, 1950. Pain was markedly alleviated and she felt and ate better. Six weeks later this woman could get into a sitting position on the side of the bed and stand without severe pain if she were assisted out of bed. Repeated x-rays showed a steady increase in the bony spread of the tumor, but the patient's attitude remained more cheerful than it had been before treatment. At the time Substance "S" was stopped, August 15, 1951, she was still moving around the bed better than at the beginning of treatment. The use of testosterone, 25 milligrams three times a week, had been continued throughout the period.

Case 4. Mrs. E.S., age 50, colored female. Two years after finding a "lump" in the right breast she had a radical mastectomy for an ulcerated lesion, followed by a full course of x-ray treatments. Ten months after the operation she had a simple mastectomy on the left side because of a fixed tumor 6 cm. in diameter. At that time 450 cc. of serosanguinous fluid was aspirated from her right chest. She was given Substance "S" in 40 milligrams doses three times a week beginning February 21, 1951, for a total dosage of 3.740 milligrams. On May 13, 1951, she had an ileo-transverse colostomy because of incomplete bowel obstruction due to peritoneal implants of adenocarcinoma. Other implants were felt and seen diffusely spread throughout the abdomen, thought not on the ovarian surfaces. Abdominal distress lessened, no ascites had developed to date, and further fluid has developed in the chest although the patient has never been fully relieved of dyspnea. Repeated x-ray examinations disclosed changes in both lungs not conclusive for cancer. After cessation of the medication the patient described a sharp decline in comfort and energy and she lost seven pounds in two months whereas previously she had maintained her weight for five months.

We have been unable to find any reference to the use of Substance "S" in the treatment of cancer. Peters[1] recently described its benefit on patients with a variety of non-malignant diseases. While giving it to a patient with metastatic cancer in the liver who also had severe hay fever, he noted a persistent mild euphoria and decreased need for opiates, and suggested to us that it might be of value in ameliorating the suffering of some of our breast cancers in the terminal stages. Selection of the dosage was largely arbitrary and depended mainly upon Peters' description of its merit from doses in the neighborhood of 10 to 25 milligrams daily. One patient developed a mild rash while under treatment which disappeared on cessation of medication for one week. No other reactions were noted, nor were there withdrawal effects other than lessening the feeling of well-being.

SUMMARY

Twenty patients with incurable breast cancer, some of whom had maximum treatment with surgery, x-ray, and sex hormones, were treated with injections of Reichstein's "S", a mineral corticoid, over periods ranging up to nine months and with total dosages up to 5,700 milligrams. Improvement in nutrition and morale with lessening of pain occurred in 13, all of whom received the Substance for three months or longer. No undesirable side-effects were noted, and no physiological alterations were suggested on repeated determinations of the serum sodium and potassium. In no case was a change seen in the histology of the tumor as studied by repeated biopsies, nor was regression or recalcification noted in any osseous metastasis. Four patients showed changes of an objective nature, enough to warrant reporting their cases.

We are familiar with the difficulties inherent in attempts to evaluate the worth of palliative measures against cancer because of the great variability observed both in the clinical behavior of the tumors and in the response of the hosts. Obviously, Substance "S" is not a cancer cure nor has it in our experience caused even such regression in tumor growths as has been described

in occasional cases treated by the sex hormones. However, we feel that the subjective improvement noted in our patients treated with the compound warrants further study of its use in the palliative treatment of late, incurable cancer.

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A Report on the Visual Screening Program in the Public Elementary Schools of Oak Park (Illinois) for 1950-51

Palmer Good, M.D., and Helen Holmes, R.N., B.S.,
Oak Park

For over twenty years, Oak Park has had an annual vision screening program for the public elementary children. Up to 1945, the Snellen "E" chart as furnished by the National Society for the Prevention of Blindness was used with the window card and controlled reflected light. About four years ago it was thought that perhaps a more sensitive method was desirable and the aid of the Illinois Soeiety for the Prevention of Blindness was sought. They loaned us two units of the Massachusetts vision testing equipment to use for two years. During these two years, we were not fully satisfied with the results of this vision testing equipment beeause we had too many needless referrals and the musele testing for the smaller children was time eonsuming and uneertain. During the loan period when we had two pieces of equipment, it became evident that there should be testing equipment in each school for re-checks, new students, and former absentees. The cost of equipping eleven schools with the Massachusetts equipment was considerably over our budget.

We found valuable suggestions in an artiele written in 1944 by Sloan and Gallagher, who modified the Massachusetts test so that it would be quantitative and more adaptable to adolescent boys. Their home made simple equipment and logieal breakdown of statistics appealed to us. We felt that many of the visual aeuity overferrals could be reduced especially in the lower grades if we returned to the Snellen "E" chart and if at a later date we reehecked all children who failed the first screening test. We wanted all sizes of letters instantly available on the ehart so that visual acuity at a specific distance could be recorded. Also these various size letters should be instantly available for ehecking and recheeking the younger children so that the examiner is frequently reassured that the child really understands the "E" game. The third reason for using the entire Snellen chart is that smaller children need to begin on the larger letters so that they get the feeling of sueeess before going on to the point where it beeomes diffieult for them. The recording of eaeh ehild's visual acuity on his sehool reeord helps keep our teaehers better informed so they ean seat the children appropriately and increase their scope of understanding of his reading difficulties.

To keep hyperopia referrals to a minimum, we selected a plus 2.00 pair of glasses for the children in grades three through eight, and a plus 2.50 for the younger ones. They were sereened on the 20/30 line. The test was given binoeularly because this might encourage relaxation of the eiliary muscles, and also save time.

We felt that something different was needed for the detection of muscle defeets, especially if it were to be used successfully in the kindergarten where its value as far as results from treatment are eoneerned, would give the greatest

Presented before the Section on Eye, Ear, Nose and Throat, 111th Annual Meeting, Illinois State Medical Society, Chicago, May 23, 1951.

benefit. The aims in designing this test for muscle imbalance were:

1. That it could be used in the usual undarkened school room
2. That it would check with a cover test
3. That it give consistent results even in the kindergarten, and with examiners who have had only a short period of training with no previous experience in eye testing
4. That the detection of suppression be included in the same test.

The equipment devised was a metal box containing a square illuminated target placed 30 inches from the eyes so as to subtend 10 prism diopters. To administer the test the child is moved before an eight degree prism so that he looks through it first with one eye and then the other. This uses the principle of prism dissociation. If the child sees two squares that do not touch each other, he has more than 2 diopters hyperphoria or more than 10 diopters esophoria or exophoria or tropia at 30 inches. If he can see only one, he is suppressing. It seemed to us that this intermediate position could take the place of the far and near tests for practical school screening purposes.

The entire vision screening test was given to all children in first through eighth grades during the second and third weeks of school in the fall and was a part of the total physical inspection program given at that time. The personnel conducting the inspections include speech therapists, a physical therapist, physical education teachers, and school nurses. The inspection includes:

1. Inspection of the scalp with a Woods light to detect suspicious ringworm of the scalp.
2. Inspection of mouth, tonsils, and inspection of skin for any skin eruptions
3. Pure-tone audiometric test
4. Vision screening — visual acuity, hyperopia, muscle imbalance and suppression
5. Weighing and measuring
6. Individual speech test
7. Posture and foot inspection

The kindergarten children are not examined in September for psychological reasons. We feel that the child at this age needs some time to adjust to school and is not ready to submit to tests given as a group. The tests for them are scattered throughout the year.

The entire program above required nine adults on each of two teams. Two adults and two eighth grade girls were used for the visual screening. Each team averaged 200 students per day or 40 per hour. One adult tested visual acuity and the other placed the children in front of the muscle test. One eighth grader put on the hyperopia glasses and the other used the window card in front of the Snellen "E" chart. A nurse was in constant touch with each team, having instructed the adults on procedure, and having set up the equipment in advance. At no time did the eye examinations, which we have described, become the bottle neck in the extended screening program.

Each child had his own form on which was recorded his visual acuity for each eye and if he wore glasses, his acuity with and without correction. The hyperopia and muscle tests were marked "pass" or "fail". Each child was given the entire test and was not told if he failed or passed.

At a later date, each failure and questionable visual condition was checked by the nurse in charge. From these individual records, each school and grade itemized their defects as follows:

Number of children not wearing glasses ——
Number less than 20/30 one eye ——
Number less than 20/30 both eyes ——
Number failing hyperopia test ——
Number failing muscle test ——
Number of children wearing glasses (tested with their glasses on) ——
Number less than 20/30 one eye ——
Number less than 20/30 both eyes ——
Number failing hyperopia test ——
Number failing muscle test ——

Also —— Number of children failing the hyperopia test who were in the lower half of their class scholastically.

From these reports the defects were tabulated in Table No. 1. Table No. 2 was derived from Table No. 1 showing the percentages of the various defects. Before drawing conclusions from these two tables, it must be borne in mind that Oak Park has had an annual screening test for many years and cannot be compared to school systems where the testing has been done intermittently or not at all. To help make comparisons easier, we believe that we should separate our report into two main groups, first those that

Table 1

		K	1	2	3	4	5	6	7	8	Total
Total number of children		531	472	552	515	458	430	398	440	377	4173
Not wearing glasses		520	461	521	481	405	376	336	364	303	3767
Less than 20/30 one eye	(A)	16	14	11	17	8	14	10	7	9	106
Less than 20/30 both eyes	(B)	15	4	8	6	9	6	4	8	7	67
Total of above (A & B)		31	18	19	23	17	20	14	15	16	173
Failing hyperopia test		*	6	5	5	7	8	4	10	4	49
Failing muscle test		6	8	9	2	6	5	4	7	4	51
Wearing glasses		11	11	31	34	53	54	62	76	74	406
Less than 20/30 one eye	(C)	1	2	5	8	5	2	9	9	9	50
Less than 20/30 both eyes	(D)	2	3	7	3	4	4	4	9	4	40
Total of above (C & D)		3	5	12	11	9	6	13	18	13	90
Failing hyperopia test		*	0	0	2	1	1	1	1	0	6
Failing muscle test		6	5	11	6	8	5	6	3	0	50
Both groups together — number failing hyperopia in lower half of class		*	1	2	0	0	0	1	4	6	14

TABLE No. 1—Table of failures according to grades, divided into those who do and those who do not wear glasses.

*Not done in kindergarten.

Table 2

	K	1	2	3	4	5	6	7	8	Av.
Not wearing glasses	97.9	97.7	94.4	93.4	89.0	87.4	84.4	82.6	80.4	89.6
Less than 20/30 either or both eyes	6.3	3.8	3.4	4.4	3.7	4.6	3.5	3.4	4.1	4.13
Failed hyperopia test	*	1.3	0.9	1.0	1.5	1.8	1.0	2.3	1.0	1.35
Failed muscle test	1.1	1.7	1.6	0.3	1.3	1.2	1.0	1.6	1.0	1.20
Wearing glasses	2.1	2.3	5.6	6.6	11.0	12.6	15.6	17.4	19.6	10.30
Less than 20/30 either or both eyes	27.0	45.0	38.5	31.3	16.9	11.1	22.6	23.6	18.0	25.80
Failed hyperopia test	*	0	0	5.8	1.8	1.8	1.6	1.3	0	1.53
Failed muscle test	54.3	45.0	35.0	18.8	15.0	9.3	9.7	4.0	0	21.20
Both groups together										
Less than 20/30	6.4	4.9	5.6	6.6	5.6	6.2	6.7	7.5	7.6	6.30
Failed hyperopia test	*	1.3	0.9	1.3	1.7	2.1	1.2	2.5	1.1	1.35
Failed muscle test	2.3	2.7	3.6	1.6	3.0	2.3	2.5	2.2	1.0	2.37
Total wearing glasses plus all failure for vision: hyperopia, muscle & fusion	9.5	9.1	11.5	12.3	17.5	20.2	21.1	24.7	25.7	18.40

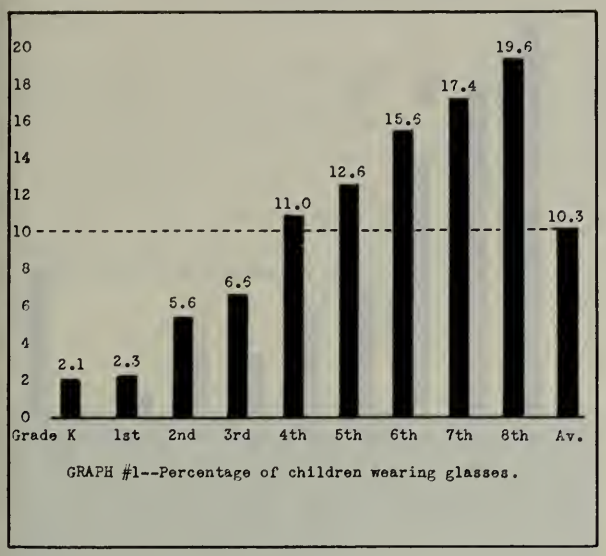
TABLE No. 2—Percentage of failure according to grades and groups, with glasses, without glasses, and both together.

*Not done in kindergarten.

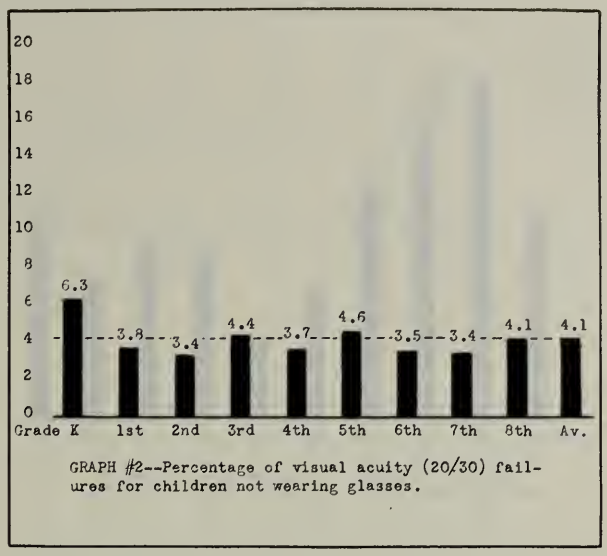
do not wear glasses and second those that do. Also we have been very fortunate to have had excellent cooperation between our nurses, parents and doctors for many years, and have had nearly 100% follow-ups for all visual referrals. This splendid cooperation seemed threatened during the two years when there were so many needless referrals with the Massachusetts equipment. From Table No. 2 we derive Graph No. 1, which shows the percentage of children wearing glasses in each grade. Note the steady increase until nearly one in five is wearing glasses in the eighth grade. It is also noteworthy that so few, only 2.3% wear glasses in the first grade.

Graph No. 2 shows the percentage of children not wearing glasses referred for less than 20/30 vision in one eye or both eyes. Note that the percentage is quite uniform for all the grades averaging 4.13, the lowest 3.4%, the highest 6.3% in the kindergarten.

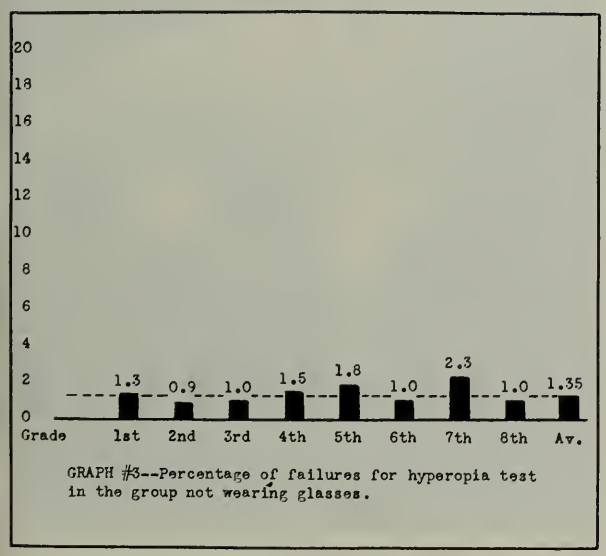
Graph No. 3 shows the percentage of children not wearing glasses failing our manifest hyper-



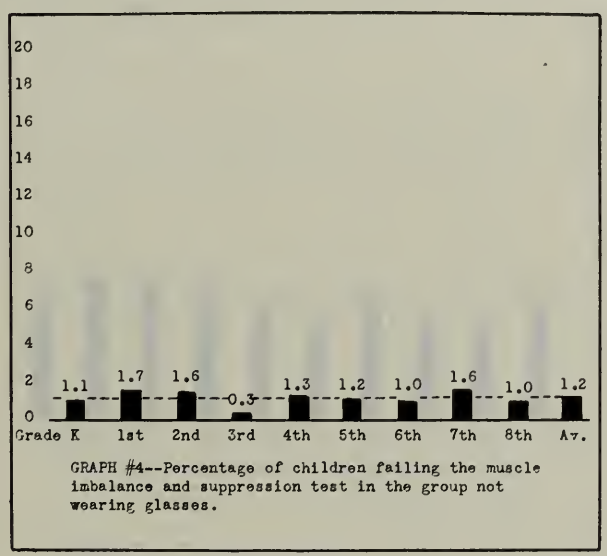
GRAPH #1--Percentage of children wearing glasses.



GRAPH #2--Percentage of visual acuity (20/30) failures for children not wearing glasses.



GRAPH #3--Percentage of failures for hyperopia test in the group not wearing glasses.



GRAPH #4--Percentage of children failing the muscle imbalance and suppression test in the group not wearing glasses.

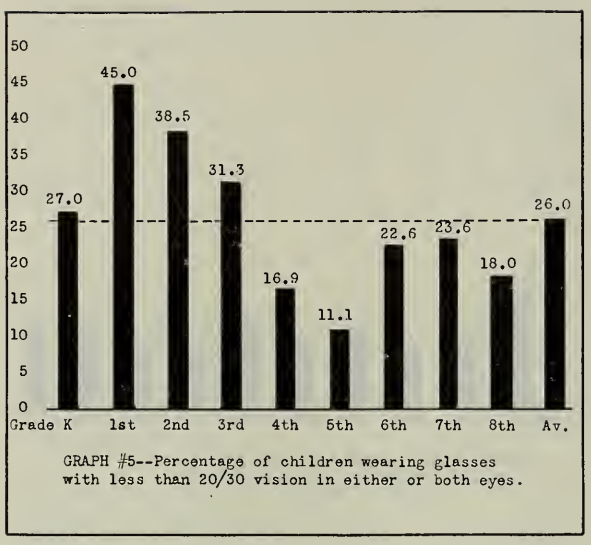
opia test. Here again the percentage is very uniform averaging 1.35%. The lowest .9% and the highest 2.3%.

Graph No. 4 shows the percentage of children not wearing glasses failing the muscle and suppression test. The overall percentage was 1.20 with a variation from .3% to 1.7%. This average is slightly lower than the estimate made by Scobee[2] of 1.5%, but as will be pointed out later, will be substantially higher when the group wearing glasses is added.

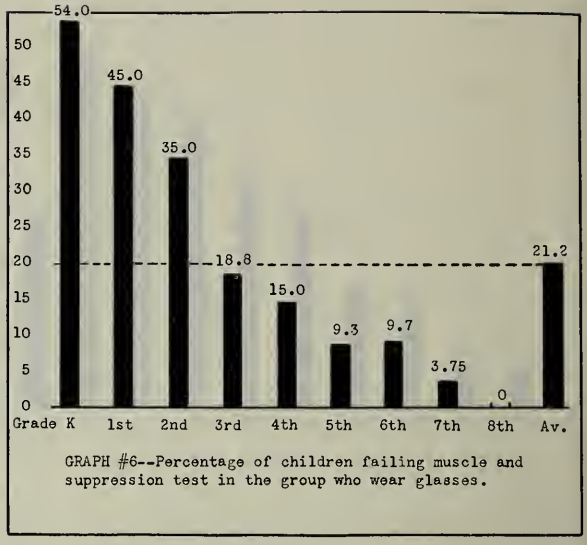
We were undecided for a long time if we should test children who were wearing glasses. Obviously they are under the care of a specialist and the school should not interfere or criticize in any way. However, we know that many of these children did not have yearly examinations and it seemed logical to refer the children with less than 20/30 vision in either of both eyes if more than one year had elapsed since the last visit to their specialist. Surely children with subnormal vision should have at least this minimum care. These children were therefore examined and were found to give the startling results shown in Graph No. 5, which shows the percentage of children wearing glasses with less than 20/30 in one or both eyes. Note the great increase of 25.8% average over 4.1% in the group not wearing glasses. Our teachers and nurses were reminded of the many children wearing glasses who did not have normal sight for one reason or another.

An average of 1.53% of the group wearing glasses failed the hyperopia test. This could be due to error in the test, corrections made without cycloplegics or a correction considerably lower than the full cycloplegic finding.

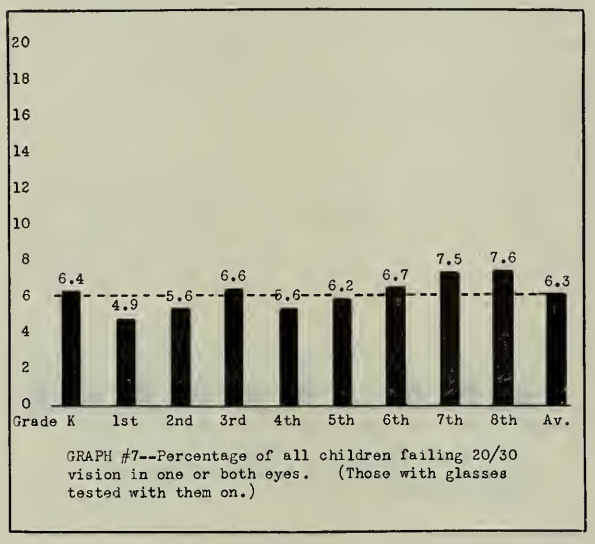
Graph No. 6 shows the large number of chil-



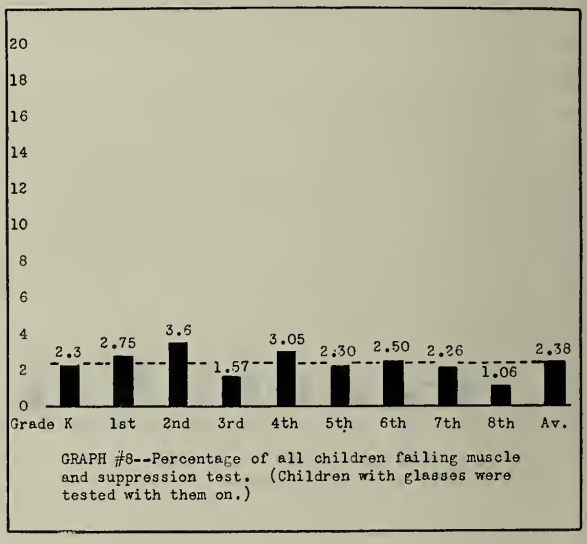
GRAPH #5--Percentage of children wearing glasses with less than 20/30 vision in either or both eyes.



GRAPH #6--Percentage of children failing muscle and suppression test in the group who wear glasses.



GRAPH #7--Percentage of all children failing 20/30 vision in one or both eyes. (Those with glasses tested with them on.)



GRAPH #8--Percentage of all children failing muscle and suppression test. (Children with glasses were tested with them on.)

dren wearing glasses who fail the muscle and suppression test. Note how it diminishes from 54% in the kindergarten to nearly nothing in the eighth grade. The average is 21.20%.

If the two above groups are grouped together remembering that children with glasses were tested with them on, we have Graph No. 7 for visual acuity failures. An average of 6.30% with the low of 4.9% in the first grade and a high of 7.6% in the 8th grade. The Muscle imbalance and suppression test is shown in Graph No. 8 which shows an average of 2.38% with a low of 1.06% in the eighth grade and a high of 3.6% in the second grade.

Our total number of referrals was not equal to a summation of the three groups of defects because first, some children failed more than one test, second, many of the hyperopias were not referred because they were doing better than average work, and finally, some of the children had been to their specialist within the preceding 12 months. We do not as yet have an accurate record of actual referrals for this year, so we must list all of our defects even though several defects may have occurred in the same child. If we use the report of Turner and Potter[3] as representative of another type of screening, we may then approximate a comparison.

Roughly our percentages are about one-half of the Peoria report. This brings up the possibility that the two referrals for each child that needs treatment as reported as over-ferrals by Scobee[4] may have been considerably reduced by our screening method.

Figure 1 shows our experimental muscle imbalance and suppression test box. The operation of the suppression and muscle test is very simple. Kindergarten children can indicate the position

	I	II	III	IV	V	VI	VII	VIII
Children with visual problems	25.1%	26.6%	29.0%	33.9%	33.0%	37.9%	37.29%	53.3%
Children below minimum standard	18.5	17.2	18.2	17.9	17.7	16.7	16.5	15.0

NOTE: The percentage of children with visual problems includes those who were below minimum standard in screening plus the children who had professional attention during the past year.

Our percentages as close as they can be fitted are as follows:

Children wearing glasses plus failures	9.1%	11.5%	12.3%	17.5%	20.2%	21.1%	24.7%	25.7%
Children failed for vision, hyperopia, muscle and suppression defects	6.8	5.9	5.7	6.5	7.6	5.5	7.3	6.1

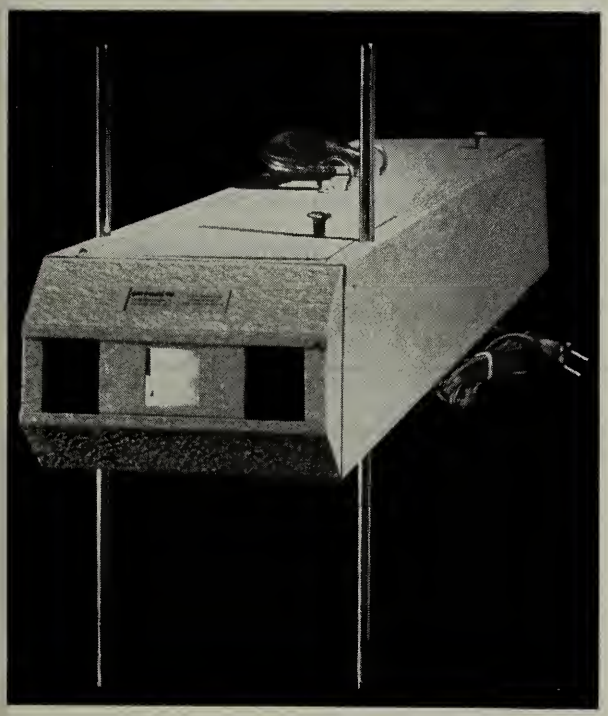
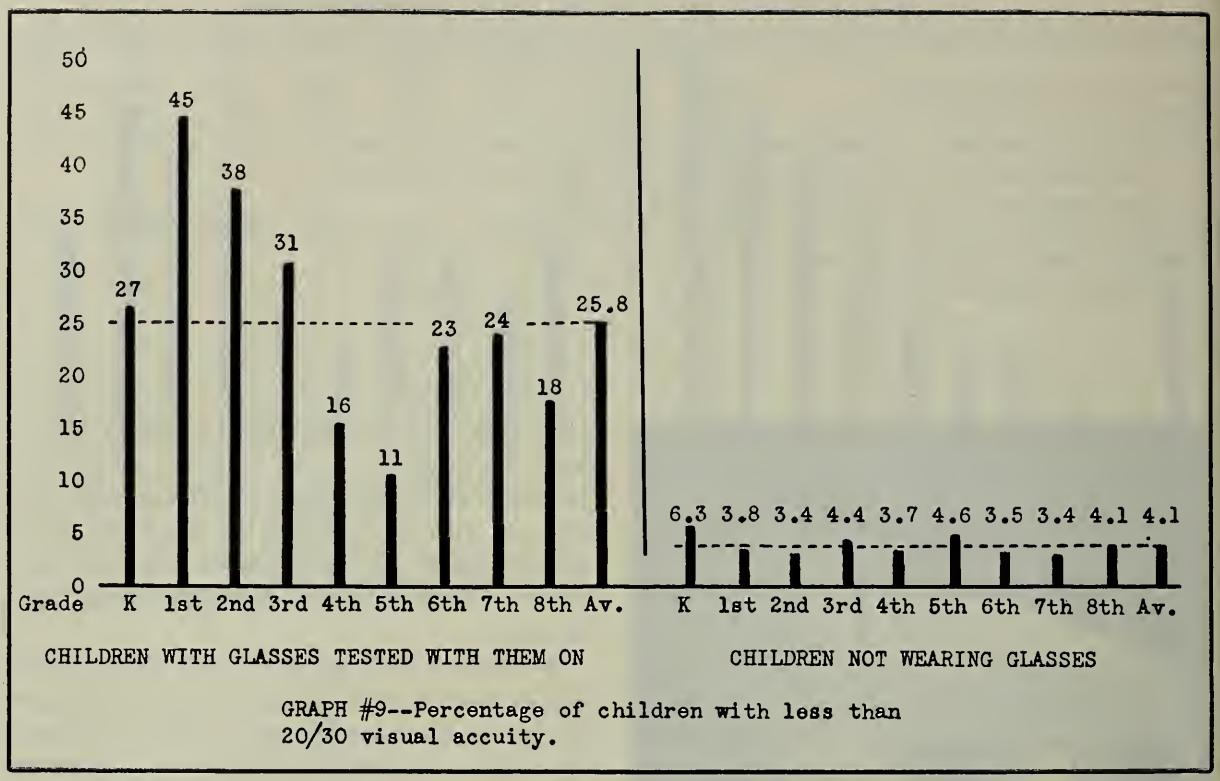


Figure 1

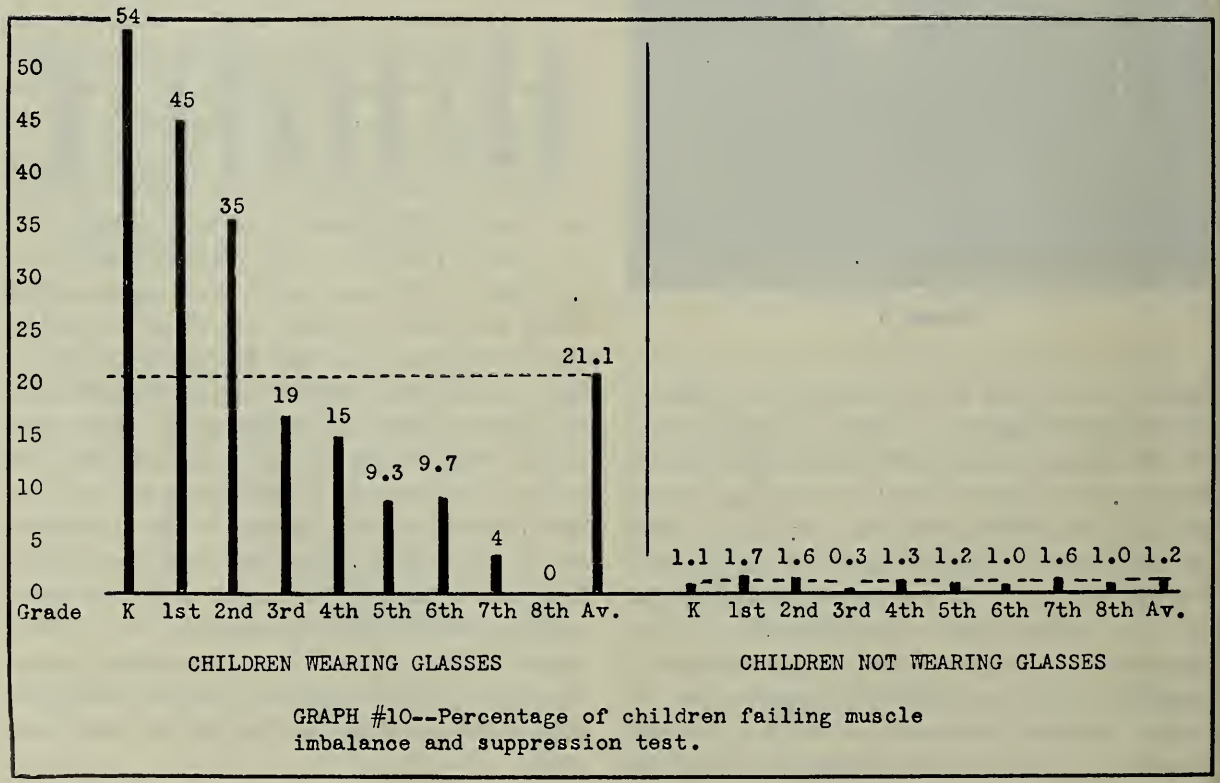
of the square in the box by placing two cardboard squares on the table in a similar position. Some of the children seeing two squares that did not touch were checked with a cover test and found by one of us (PWG) to tally very well. Also the suppressors (those who saw only one square), for the most part showed noticeable motion of the eyes under cover. Not only did this test check with a cover test, but the percentage of referrals was about that anticipated; for example, Scobee's[2] estimate of 1.5% is closely matched by our 2.4%. We therefore feel that for the present, we are screening an adquate number of children for muscle imbalance and suppression. Last year (1949-50) we referred 42 children from several of our schools for muscle imbalance or suppression and 24 or 57% received correction. This would seem to indicate that at least the majority of our referrals needed correction. The only change we contemplate making next year is to reduce the frequency of the test to perhaps the kindergarten, third and sixth grades. New students should of course, also be tested.

We would like to point out that children with glasses have as a whole, much poorer vision and muscle balance than the other children not wearing glasses. Graph No. 9 shows this difference especially in the lower grades. Graph No. 10 shows the difference for muscle inbalance and suppression. Here again the difference is striking in the lower grades. The fact however, that a child does or does not wear glasses, should not influence a teacher or nurse in the placement of a child in his school room. His individual visual acuity should be a record for ready reference at any time. There are many children with vision less than 20/30 and better than sight saving vision who must be taken care of in the regular school. Teachers and parents should understand this problem and provide visual education designed for a child with 20/40 vision rather than 20/20. This has been done quite well by using large print in the books of the smaller children, but blackboard work, lantern slides, etc. often are not fitted to a child with sub-normal vision. From our statistics, it seems there are many children who cannot be corrected or for other reasons do not get 20/30 vision even with glasses. They are a sizable group and should have available to them all the advantges the school can offer.

There appears to be at the present time no unanimity among ophthalmologists regarding the effect of excessive hyperopia on a child's reading ability or what comprises excessive hyperopia for a certain age barring crossed eyes. In 1949-



GRAPH #9--Percentage of children with less than 20/30 visual accuity.

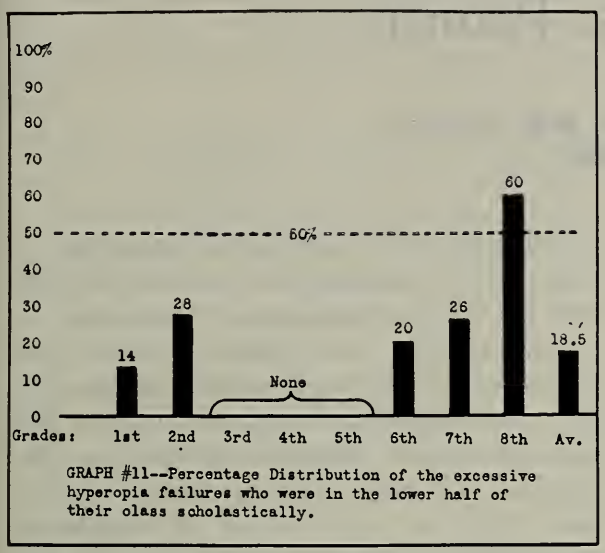


GRAPH #10--Percentage of children failing muscle imbalance and suppression test.

50 we obtained about 11% failures when we used plus 2.00 glasses for the older children and plus 2.50 for the younger and failing all those that could read the 20/40 line. Even after eliminating those that were doing better than average school work, only 11 out of 32 in a few of our schools were given corrections.

This year 1950-51 we used the same glasses

but failed those that could read the 20/30 line. This gave us 1.5% as shown in Table No. 2. Most of these children were doing better than average work. Of the 54 failures only 14 were



GRAPH #11--Percentage Distribution of the excessive hyperopia failures who were in the lower half of their class scholastically.

doing less than average work. Graph No. 11 shows the distribution of these failures. Only in the eighth grade were there more than 50% in the lower half of the class. We were therefore not able to establish the fact that hyperopia is a handicap to reading, except possibly in the upper grades. It seems that hyperopia or farsightedness, unlike myopia, does not indicate a refractive error that in itself requires correction.

It is too early to report on the follow up of the 1950-51 year. But we can report on 1949-50, which showed 121 children given correction for visual acuity out of 142 referred; 11 out of 42 corrected for hyperopia and 24 out of 42 for muscle imbalance or suppression. Some schools did not break down their referrals so adding all together we had 338 referrals with 284 corrections.

Because our number of referrals was relatively small, it could be argued that many children should have been referred that were not. To check this possibility, all the ophthalmologists of Oak Park were asked "Have you found children in your office from our elementary schools who should have been referred and were not". The majority answered this question "No". We also asked them "Have the unnecessary referrals of three and four years ago been held to a minimum". The answer was "Yes". In spite of these reassuring answers from the Profession, our nurses and teachers are warned that complete eye testing is difficult and involves many tests that cannot be given in school. Therefore all children with inflamed eyes, poor reading positions or those not working up to capacity should be referred as well as those failing our screening test.

CONCLUSIONS

1. Visual acuity needless referrals may be reduced to a minimum by having an understanding examiner test the children with a standard Snellen "E" chart, and by having all failures retested at a later date.
2. A simple test for suppression and muscle imbalance based on prism dissociation has been found to check with the cover test and give 2.37% referrals.
3. The value of a manifest hyperopia test in the grade school is very questionable. It will probably be eliminated from our lower grades.
4. Children wearing glasses should be screened along with the others.
5. Visual acuity should be a part of every child's school record and should be used in planning his seating and activities.
6. We have not perfected a screening system and probably never will, but feel that we have started on the right track by keeping our parents' confidence with a minimum of over-referrals. Should it seem advisable at a later date to increase the number of referrals, the way is open to raise our standards. For example: the older children could be screened at 20/25, a near point test could be added or the amount of prism tolerances reduced.

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Surgical Management of Cutaneous Tumors

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The purpose of this paper is to emphasize the necessity for absolute diagnosis and adequate treatment of those cutaneous neoplasms which are or ultimately may be of serious import.

The tendency of some physicians to use inadequate and uncontrolled procedures for treating cutaneous tumors, often in the office and many times without pathological examination, prompted the discussion of this commonplace and somewhat trite subject.

It is not necessary to dwell on the management of such obviously benign and simple entities as sebaceous cyst, lipoma, verruca vulgaris, neurofibroma and the like. These are not serious problems, but their differential diagnosis may be. The only surgical problems involved in these are those of careful surgical technique and pathological examination of removed tissue. It is well to bear in mind that removal of these lesions under any but the most aseptic conditions may result in infection and subsequent disfiguring scar. The most benign appearing lesion may occasionally reveal early malignant changes on microscopic examination.

The cutaneous tumors most commonly mishandled are those in the phase between the obviously benign and obviously malignant. Most common among the precancerous lesions are:

1. Cutaneous horns
2. Senile keratoses
3. Arsenical keratoses
4. Nevi, or moles
5. Leukoplakia

Cutaneous horns are horny growths usually occurring in later life, most commonly on the face or hands. They are usually single and may vary from a few millimeters to several centimeters in length. The base is composed of well-differentiated squamous-cell carcinoma in about 10% of cases and thus, nothing less than thorough exterpation is adequate treatment.

Senile keratoses are common in elderly individuals with senile skin, especially in those persons whose occupations require exposure to long hours of sunlight. They are multiple, flat, gray or brown and may vary from dime to quarter size. When they occur on the lip these lesions are especially dangerous. Commonly the neglected keratosis is transformed into squamous-cell carcinoma. The seborrheic keratosis is similar, but is readily differentiated and is a benign lesion. The senile keratosis should be treated by radiation under ordinary circumstances, but only after biopsy has proven that malignant transformation has not occurred.

Arsenical keratoses are keratotic lesions which develop after arsenic therapy or industrial exposure. They are characteristically found on the palms or interdigital areas. The usual keratosis degenerates into squamous-cell carcinoma although many years may elapse before such transformation takes place. It is wise to avoid arsenical drugs in any patient who tends to develop keratotic lesions for arsenic is carcinogenic in these individuals.

Treatment of this lesion is surgical and may require extensive resection and skin grafting. Radiation therapy is not effective.

Nevi are probably the most important of the premalignant lesions encountered in everyday practice. The most common of these are the pigmented moles. They are usually congenital and make themselves evident in the first few months of life. Becker lists the distribution of nevi in the following order:

Face	41.0%
Trunk	27.0%
Neck	10.0%
Lower extremity	6.5%

Presented before the Section on Surgery, Illinois State Medical Society, 112th Annual Meeting, Chicago, May 13-15, 1952.

Upper extremity	4.5%
Scalp	2.0%
All other	9.0%

The most common lesion mistaken for a nevus is the seborrheic keratosis, which is commonly pigmented, slightly raised and usually on the face.

There is considerable difference of opinion regarding the malignant potential of incompletely removed pigmented nevi. Slaughter, Becker and Tobias believe that these lesions were malignant originally and undiagnosed. Gage and Dawson believe that "meddlesome surgical interference converts a benign into a maligant melanoma and is responsible for 75% of local recurrences". Many others agree with this viewpoint.

From the standpoint of the surgeon and general practitioner, certain criteria for removal are clear:

1. Any nevus showing changes in color or size.
2. Any nevus which is ulcerated or bleeding.
3. Any nevus exposed to constant irritation or potentially so exposed.
4. Any nevus under the nail.
5. The brown or black nevus which has its onset during adult life.

It is agreed that nevi practically never become malignant prior to sexual maturity, but often do so thereafter, especially if of the benign melanoma or junction type. Therefore, prophylactic removal is advisable in the prepubertal child when located in areas subject to irritation or likely to be irritated, as in the beard area of the boy or where underclothing may constantly rub.

The use of fulgeration with high frequency current, cautery, solid carbon dioxide or escharotics is to be condemned in any but the most obviously benign moles, since biopsy cannot be done and removal is rarely complete. Such treatment is used by many dermatologists, but the general practitioner or the surgeon is rarely so sure of his diagnosis. X-ray and radium have no place, as these tumors are radio-resistant. One should not hesitate to remove a dangerous nevus from the face with 1 or 2 millimeters of uninvolved skin surrounding even if grafting is necessary to fill the defect. Such a procedure is simple and the results are very satisfactory.

Leukoplakia generally is found on the exposed portion of the lips in individuals whose occupations subject them to long hours of actinic rays. It is characterized by piling up of the epithelium with white discoloration of the mucous membrane. Its malignant progress is toward squamous-cell carcinoma. Treatment consists of careful excision of the involved area with undermining of the normal mucous membrane to the root of the lip. This is then approximated to the skin to reconstitute the vermilion border. Very little scarring or deformity results and the procedure is readily accomplished under regional block anesthesia.

The malignant cutaneous tumors most commonly seen, basal-cell carcinoma, squamous-cell carcinoma and melanoma are all treated surgically at times.

Basal-cell carcinoma can be cured in all but the advanced stages by any adequate locally destructive procedure. X-ray or radium therapy is considered by most authorities to be the most effective except when, by location, this medium is dangerous to underlying or surrounding structures. The areas where surgical excision or radical currettment are preferred are over the ear, distal nose and eyelids. In these special regions, adequate removal with skin graft, if necessary, is the treatment of choice. Again it is well to emphasize that 2 to 3 millimeters of normal skin should be exised around the lesion to assure a complete destruction.

Squamous-cell carcinoma, because of its tendency to lymphatic spread must be treated in a much more radical manner. Wide excision of the primary tumor is mandatory and dissection of the regional nodes should be performed in all except the earliest lesions. Squamous-cell carcinoma occurs most commonly on the vermilion border of the lip and as a result of malignant degeneration of keloids, burn scars, senile keratoses, arsenical keratoses and leukoplakia. Malignant ulcerated skin tumors in the extremities are virtually all squamous-cell carcinoma. Metastases are found in 15% to 20% of cases. Taylor, Nathanson and Shaw, in an analysis of 238 cases of squamous-cell carcinoma of the hand, report 14% metastases. It is therefore essential that these patients be closely observed and radical regional node dissection be performed (1) immediately in younger patients or with

large infiltrating tumors, (2) if nodes appear after complete removal of the primary tumor. Many of these patients thus can be salvaged.

Maligant melanoma is the most malignant and most rapidly metastasizing tumor of the skin. Webster has concluded that about 65% of melanomas develop from nevi. It is therefore essential that all nevi in areas of irritation, especially the extremities, be removed.

The subungual melanoma or melanotic whitlow is commonly misdiagnosed as a chronic granuloma or pyogenic whitlow. Many have a pigmented border. All pigmented lesions or chronic granulomatous lesions around or under the nail should be biopsied.

Much has been written on the treatment of malignant melanoma as in any condition where no treatment is uniformly satisfactory. A careful analysis of all methods proposed brings one to the conclusion that the rule of wide excision followed by microscopic confirmation of the diagnosis and subsequent careful and thorough dissection of all regional nodes will save many patients. As in cancer surgery elsewhere, the faint heart has few five year survivals.

In conclusion, the principles outlined by Conway for the excision of malignant tumors of the face can be applied to the excision of malignant skin tumors anywhere:

1. Generous estimate of the amount of tissue to be removed with the tumor.
2. Placement of incisions parallel to the lines of elasticity of the skin when possible.
3. Unhesitant sacrifice of important anatomic structures in the neighborhood.
4. Resection of regional lymph nodes if involved.

To these may be added:

5. Excision biopsy of all suspicious lesions.
6. It is better to excise a benign lesion than to incompletely remove a maligant one.

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SEX HORMONES

One hormone aids the action of another, a synergistic pattern of action. In the first half of the menses the female hormone, estrogen, does its work; then, as it decreases, another female hormone, progesterone, increases and is in control until the end of the month when it in turn decreases and the uterine lining is shed. Not only is there an orderly sequence of estrogen-progesterone, but one hormone requires the action of the other, for by itself progestone even in small doses markedly changes the lining. This syngergistic effect depends upon careful balancing, and the amount of each hormone must be exactly calculated, for even though progesterone cannot influence the uterus until this organ is prepared by estrogen, too much estrogen causes progesterone to become powerless. *Ralph Colp, Jr., M.D., A Half Century Of Hormones. New York J. Med. May 1, 1953.*

EDITORIALS

POLIO PREVENTION PROJECTS

Last year 54,772 children were inoculated against polio with gamma globulin in epidemic areas in Utah, Texas, and Iowa. In June of this year more than 30,000 youngsters in Montgomery, Ala. received GG as part of a mass inoculation project and in July, a similar program was completed in Caldwell County, N. C. Since the polio season is still young, other epidemic areas throughout the country undoubtedly will arrange for Operation GG.

What is the modus operandi of these mass inoculation programs? One of your editors visited Caldwell County on July 8 and learned that for many years polio had been almost endemic in this and two neighboring counties (Burke and Catawba). In this rural area most victims live in the rills where there are no unusual factors associated with transmission of the disease such as flies, mosquitoes, or poor sanitation.

In the North Carolina epidemic the first case was reported in April — a child of 2 who died. By July 8 there were 94 cases. During this period the members of the Caldwell County Medical Society were kept busy with requests for gamma globulin every time a new case appeared. When the physician decided that the vaccine was unnecessary, the parents shopped around from one physician to another. Because of the pressure, a county medical society meeting was called and it was decided to pass on to the county health officer, Dr. William Happer, the decision on whether or not GG was required. Meanwhile, as more and more cases were reported the city fathers demanded action and when it was established that an epidemic existed, Dr. Happer approached the state board of health with the idea that approval be obtained from the Office of Defense Mobilization to give all children under 10 appropriate doses of GG. This approval was granted by ODM.

The number of cc's needed was determined by estimating the number of children in the county in this age group and multiplying by 10. There are 43,000 inhabitants of Caldwell County and they estimated there were 10,200 children under 10. This figure is high by the usual standards but it later proved surprisingly accurate. The next step was to ask the National Foundation for Infantile Paralysis for their support in lending the necessary equipment and experience in running a mass inoculation project. The response of this organization was phenomenal; within 24 hours, six of their representatives were in Caldwell County and the essential syringes and needles were on their way.

Arrangements were made to hold clinics in four schools scattered throughout the county, with eight inoculating tables each. Forty phy-

sicians agreed to work in four hour shifts assisted by 60 nurses and more than 400 volunteers. The latter proved to be the key to the smooth operation of the project. A prominent club woman was selected to act as chairman and she in turn called upon the leaders of all the other women's organizations and the teachers to supply volunteer workers. The leaders were briefed on what to do and they in turn briefed others. A film made by the National Foundation during the Houston, Texas program of 1952 proved invaluable.

The blood arrived and the people were informed by word of mouth and through newspapers, radio, and churches that GG was available for all children under 10. The clinics were open from 9 a.m. to 9 p.m. and by the end of the second day approximately 10,000 youngsters had received the serum. The dosage was calculated on the basis of the child's weight and most youngsters were given less than 10 cc's. (1.5 cc for 10 lbs or less to 14 cc for those 100 lbs or more) By the third day there was enough left over to inoculate children up to age 15 on the basis of "get it while it lasts."

The entire program worked smoothly; there was no hysteria and the community feels satisfied that everything possible is being done to control the epidemic. At the time of this writing the outcome is unknown. Regardless of how we feel about the merits of GG there is no doubt that the burdens of the medical profession in this North Carolina community have been lightened during this polio epidemic.

WOMEN IN MEDICINE*

Early in the fall of 1951, a brief questionnaire was prepared and mailed to all of the women who graduated from the College of Medicine of the University of Illinois during the period from 1921-1945 inclusive, and who were listed in the new A. M. A. directory. During this twenty-five year period 151 women graduated.

The purpose was to learn how active these graduates are in the practice of medicine and what phases of medical practice have attracted them.

Of the 151 women who graduated in this twenty-five year period, ten are dead, and 141 are believed to be living. Of the one-hundred forty-one questionnaires which were mailed, 8 were returned by the post office and 117 were returned completed. Thus, of the 133 questionnaires which apparently reached their destination, 88% were completed and returned. The 24 graduates who were not reached, or who did not reply, were omitted from the statistical computations since it seemed reasonable to assume that at least as many of them were in medical work as of those who replied.

Of the 117 living women graduates from this twenty-five year period who completed the questionnaire, all but 12, or 90%, are now making direct use of their medical education. However, 2 of the 12 who reported not practicing now stated that they definitely planned to resume practice at some time in the future and one other said she might do so.

Every one of the 12 reporting as not in practice is married and has children. In each case the chief reason given for not practicing is the care and raising of these children. It is possible that several of them may resume practice when the children are older, since none of the 12 can be considered very aged. The oldest graduated in 1931. Health was given as a second factor in two of the 12 cases. It appears that the women of this group did not retire from the field of medicine as they grew older, but only as their financial status became secure as a result of successful marriage and their children needed them.

Most of the 12 reported that they had spent several years in private practice. One who married while a student practiced only one year. Three practiced for five years, four for six years, one for eight years, two for ten years, and one for thirteen years. In other words, 11 of the 12 practiced five years or more.

Seventy-eight of the 117 who replied are, or had been married, and 56 have children. Only one of the 117 graduates failed to practice for five years. 44 of the 117 continued to practice while raising famlies. Thirty-five married physicians. Fifteen married men in some type of business, seven teachers who were not physicians, five lawyers, three engineers and two dentists. Six reported being married, but did not mention their husbands' occupations, while the remainder married men in a variety of occupations or

*From University of Illinois College of Medicine: — Carrol Birch, M.D., Mr. Maurice Galbraith and Mr. George R. Moon.

professions. It may be significant that all of the twelve who reported retirement from medical work were married and seven of them married physicians. This leaves 105 in medical practice.

In reply to a question concerning specialization in practice, the following information was secured. Thirty-six, or 33%, of the 105 in practice stated that they have board certification in some specialty, but many more reported that they were specializing in practice. The actual number working in each specialty field is indicated below:

Psychiatry	12 plus 5 working in mental hospitals		
Ob. and Gyne	3	Dermatology	6
Pediatrics	13	Ophthalmology	3
Internal Med.	7	Surgery	2
Anesthesia	6	Pathology	1
		Roentgenology	1

In addition we find that eight are in Public Health work, five are practicing in mental hospitals, five are associated with universities doing teaching or student health work, one is a medical officer in the U. S. Army, and one is a full-time hospital administrator.

This leaves twenty-two who are general practitioners. Of these, seventeen are in full-time practice in this country and three reported only part-time practice. Two sent their questionnaires from India where they are medical missionaries, apparently working about twenty-two out of every twenty-four hours in the day.

It is interesting to note that out of 105 reporting active participation in medicine 37 or 35% have some type of university teaching appointment.

The extent of their migrations is not given but their present location gives some idea of their travels. The following list of states shows how many are now located in each:

Illinois	46	Arkansas	1
California	13	Connecticut	1
Michigan	10	Iowa	1
New York	6	Kentucky	1
Minnesota	4	Maryland	1
Oregon	3	Nebraska	1
Pennsylvania	3	New Hampshire	1
Wisconsin	3	North Carolina	1
Indiana	2	Utah	1
Tennessee	2	U. S. Army	
Arizona	1	Washington, D. C.	1

Two are in India

Some comparable data are available on men who graduated from the college during the same period. Questionnaires were sent to the men who graduated in June of the years 1928, 1933 and 1935. Only 198 replies were received from the 368 letters mailed out — 54% as compared with the 117 received from the 141 sent to the women. Four, or 2% of the men who replied have left the practice of medicine. 56% of these men are specializing in their practice, compared with some 83% of the women. However 40% of the male group, as compared with 33% of the women, report Board certificates. 31% of the men, compared with 35% of the women hold teaching appointments. More of the men have settled in their home state: 62% of the men are practicing in Illinois as compared with only 44% of the women.

Available data seen to indicate that these women medics are practicing a lot of medicine and compare very favorably statistic-wise with a comparable group of men.

ILLINOIS PLAN FOR DISTRIBUTION AND USE OF GAMMA GLOBULIN FOR POLIOMYELITIS PROPHYLAXIS

An Explanatory Note: The demonstration by Hammon and his co-workers in the Utah-Texas-Iowa students that gamma globulin may be effective in preventing or modifying attacks of paralytic poliomyelitis has created a public demand for prophylactic passive immunization far in excess of the total available supply. Despite the fact that gamma globulin is not a practical solution to the problem of prevention of paralytic poliomyelitis, the demands will increase as the incidence increases this summer. It is difficult to impress upon the public, in the face of the emotional appeal which the disease has, that gamma globulin could, at best, protect for but 4-6 weeks; that reinjections would be necessary three to four times during the months of heavy incidence; that the chance of paralytic infection among the entire child population in Illinois is only about 1 in 2,000; that determination of time of exposure is most treacherous; and that little is known of the possible effect which gamma globulin may have upon the development of natural immunity subsequent to subclinical infection.

The total national supply of gamma globulin is approximately 9,000,000 cc., which is the equivalent of 1,500,000 pints of blood. This is adequate for but a single average dose in only 1,500,000 children, not even enough for the child population of Illinois itself. One readily recognizes the problem when a *single* injection for all children under 15 years of age in the United States would require 287,000,000 cc. and *four* injections to cover the period of high incidence would consume 1,148,000,000 cc.

B. National Allocation: Recognizing these problems, the entire modest supply of gamma globulin was placed under the control of the President's Office of Defense Mobilization. Panel of experts, representing the medical and public health fields, were called upon to formulate a plan of equitable distribution, which would place the biologic where it was needed the most and where it would most efficiently aid in prevention of as great a number of cases as possible, considering the shortage of supply and the fact that mass prophylaxis of the entire child population was impossible.

The American Red Cross is continuing its Blood Program and turning over its processed gamma globulin to the Office of Defense Mobilization for distribution. The National Foundation for Infantile Paralysis has purchased, and will continue to purchase, the entire commercial supply and is turning this over to the Office of Defense Mobilization. This was the only means of preventing a black market in globulin and of assuring judicious equitable distribution. The Office of Difense Mobilization has now furnished each State Health Authority with its final plan of distribution. This plan:

(1) Names the State Health Department as the sole responsible agency for distribution within the state;

(2) Defines the limitations of use (which are reflected in the appropriate section below);

(3) Allocates the basic quantity of gamma globulin to each state according to the 5 year (1947-51) mean of reported cases of poliomyelitis; and

(4) Provides for special allocations for mass prophylaxis in communities experiencing severe outbreaks of the disease, but contingent upon consultation between State and local health authorities.

C. State Distribution Plan: The ensuing plan has been developed by the Illinois Gamma Globulin Distribution Committee. This Committee is composed of members of both the Illinois State Medical Society and the Illinois Department of Public Health. This plan has been approved by the Council of the Illinois State Medical Society and Illinois Department of Public Health.

D. Restrictions for Use: Gamma globulin distributed to private physicians will be restricted for use only in:

(1) *Household contacts up to 30 years of age,* living in the *same family unit* with the *clinically diagnosed* case of poliomyelitis.

(2) *Pregnant women, irrespective of age,* having intimate contact with *any clinically diagnosed case* of poliomyelitis.

E. Definition of Clinically Diagnosed Case: Clinically diagnosed cases of poliomyelitis include:

(1) *Non-paralytic:*

An acute febrile illness which may include one or more early symptoms as:

(a) Headache
(b) Anorexia
(c) Nausea and/or vomiting
(d) Malaise
(e) Sore throat
(f) Constipation
(g) Abdominal pain

along with nuchal-spinal rigidity and a moderately elevated spinal fluid cell count.

(2) *Spinal paralytic:*

Signs and symptoms as in non-paralytic, but *with* evident weakness of one or more muscle groups, i.e., manifest limitation of active motion of muscles of neck, abdomen, back, thorax or segments of the extremities.

(3) *Bulbar paralytic:*

Signs and symptoms as in non-paralytic, but with involvement of the cranial nerves and/or the autonomic centers.

(4) *Bulbo-spinal paralytic:*

Signs and symptoms as in both (2) and (3) above.

F. *Sources of Supply of Gamma Globulin in Illinois:* Gamma globulin for poliomyelitis will be available to private physicians at:

(1) All full-time city, county and district health department offices.

(2) Regional offices of the State Health Department.

(3) Bureau of Epidemiology, State Department of Public Health, Springfield (Phone: 6611, Extension 167).

G. *Dosage and Administration:*

(1) The recommended prophylactic dosage of gamma globulin is 0.14 cc. per pound of body weight.

(2) A simplified table based on age, but predicated upon average weights at the respective ages, may be utilized both for distribution and administration:

Age	*Amount of Globulin to be issued and administered*
Under 6 months	2.0 cc.
6 mos. thru 2 yrs.	3.0 cc.
3 yrs. thru 20 yrs.	1.0 cc. *per yr.*
21 yrs. thru 30 yrs.	20.0 cc.
Pregnant women—any age	20.0 cc.

Example: Four household contacts aged 1 yr., 7 yrs., 28 yrs. and 29 yrs. require globulin; thus 3 cc., 7 cc., 20 cc. and 20 cc. will be needed respectively for a total of 50 cc.

(3) Injection must be *intramuscular.*

(4) Injection of contacts should be performed as soon after diagnosis of the clinical case as is praticable.

(5) Poliomyelitis globulin is packaged in 10 cc. vials.

(To Distributing Centers: Supply the physician with that number of 10 cc. vials whose total contents exceeds the total amount required by no more than 7 cc. For example: If 24 cc. are required, send 30 cc. (3 vials); if 42 cc. are required, send 40 cc. (4 vials).

H. *Method of Obtaining Gamma Globulin by Private Physicians:*

(1) Have information as to name, address, age and date of onset of clinically diagnosed case, as well as names and ages of household contacts ready.

(2) Transmit this information in any one of the following ways, whichever is most expedient:

(a) *Phone* request to your nearest distributing center supplying the requisite information on case and household contacts, when globulin will be sent immediately. (Distributing center will make out request slip in lieu of physicians).

(b) Fill in and sign request slip and send with messenger or member of family to distributing center, when globulin will be issued.

(c) Fill in and sign request slip and mail (special delivery) to nearest center, when globulin will be sent by special delivery mail.

I. *Maintenance and Replenishment of Globulin Supplies at Distributing Centers:*

(1) All stocks of gamma globulin must be kept in the refrigerator between 35°F and 50°F.

(2) Replacement of the supply of gamma globulin in distributing centers will be upon the basis of the request slips executed by or for the physician:

(a) Send in all request slips to Illinois Department of Public Health, Bureau of Epidemiology (CD), Springfield, Illinois, once each week or sooner for replacement of stock.

(b) Distributing centers should keep a record of distribution by names of case and contacts for cross-checking as a safeguard against duplication of distribution. This may be in the form of duplicate request slips or the recommended "Record of Distribution."

J. *Local Medical Society Committees on Gamma Globulin Distribution:*

The Council of the Illinois State Medical Society has requested each constituent County Medical Society to organize Globulin Distribution Committees, whose purpose shall be:

(1) To provide surveillance of the use of gamma globulin within the framework of the State Distribution Plan.

(2) To assist the full-time health officers in the interpretation of restrictions, and

(3) To review and correct abuses referred by the full-time health officer by whatever means the local society elects. This may take the form of personal contact of the committee with the physician involved.

K. *Special and Emergency Use of Gamma Globulin:*

(1) *Camp and Institutional Outbreaks:*

(a) Upon the report of a *single* case of poliomyelitis in a summer camp or institution, the full-time health officer of the jurisdiction will investigate the situation immediately.

(b) The need for gamma globulin will be determined on the basis of the size of the camp or institution and the intimacy of contact among the respective units involved.

(c) Any unit with extensive intermingling, as regards sleeping, dining and activities, shall be regarded as a household and all members of the unit considered household contacts.

(d) The full-time health officer will consult with the Illinois Department of Public Health in regard to globulin needs and administration.

(2) *Mass Community Prophylaxis:*

(a) National reserves of globulin have been set aside for mass community prophylaxis in bonafide outbreak situations. These reserves will be released to State Health Departments for community use in such situations upon request of the State Health Officer.

(b) Mass community prophylaxis will be applied within the limits of the available gamma globulin supply then existing and only after consultation among the Gamma Globulin Distribution Committee, full-time local health officers and State health officials to determine the need and applicability of this method.

(c) Such mass prophylaxis will be applied only to the age group at greatest risk, i.e., children up to 15 years of age.

L. *Reporting:*

Because of the regulations laid down by the Office of Defense Mobilization in allocating gamma globulin for poliomyelitis prophylaxis on the basis of reported incidence of the disease and, in outbreaks, upon severity of the cases, it will be necessary that:

(1) All cases of poliomyelitis be reported immediately upon diagnosis;

(2) Type of disease be designated in accordance with outline in Section E (Definition of Clinically Diagnosed Case) even though type diagnosis is provisional; and

(3) All deaths from poliomyelitis be reported by physicians immediately utilizing regular morbidity report cards, marking them "Death from Polio". (This is in addition to death certificate)

M. *Note on Difference Between Measles Gamma Globulin and Polio Gamma Globulin:*

(1) Measles gamma globulin *will not* be distributed for and *shall not* be utilized in poliomyelitis prophylaxis. Measles globulin *has not* been titrated for polio antibodies and may have been derived from rural pools in which the titer of such antibodies is minimal or lacking.

(2) Polio globulin will have been titrated for polio antibodies and packages will be marked as such.

N. *Note on Revisions:*

This plan is subject to revision at any time in accordance with changes in the national restrictions availability of supply, or experience with the State Plan.

Information may be obtained from your full-time local health department, regional health office, or the Springfield offices of the Illinois Department of Public Health.

DIATHERMY INTERFERENCE WITH RADIO

Diathermy treatment of various ailments by institutions and physicians has become increasingly widespread in recent years. However, the operation of this equipment has created a problem of which many users may not be fully aware.

When operating, many diathermy machines emit radio frequency energy upon frequencies which the Federal Communications Commission must keep clear of interference. Then too, occasionally equipment is modified for special applications or experimental work and this may cause r-f emission outside of assigned frequency bands.

For these reasons, the F.C.C. has expressed its intention of seeking out all offenders shortly. Accordingly, it is likely that any diathermy installations employing offending apparatus will receive notification to remedy the condition at

once. It is also possible that manufacturers of such equipment will find themselves in difficulty with their customers. While their current models may comply with F.C.C. regulations in every way, earlier but still serviceable units of their manufacture may not.

The crack-down is due to take place beginning June 30th, 1953, the F.C.C. has indicated. Many offenders have already been located and patrolling mobile monitors with direction finders are locating more all the time. Part 18 of the F.C.C. Rules and Regulations states quite broadly who may be affected:

"The operation in the industrial, scientific and medical service, of medical diathermy equipment, industrial heating equipment, and miscellaneous equipment of a type which emits radio frequency energy upon frequencies within the radio spectrum constitutes a serious source of interference to authorized radio communication services operating upon the channels of interstate and foreign communication unless precautions are taken which will prevent the creation of any substantial amount of such interference."

A number of warnings have been given by the F.C.C. to violators of Part 18. Various factors involved have been taken into consideration and extensions have been granted. Some offenders have been continuing operations in the hope that further extensions will be forthcoming. Others are counting on the time given by an extension to make adjustments, when and if the F.C.C. notifies them. However, this course is ill-advised at best, for exceptions, it is said, will be few.

Obviously, those affected by the F.C.C. ruling must seek a solution immediately. In some cases, modifications of the equipment in use may provide the answer . . . or the purchase of new equipment which does not cause interference. Either of these courses may be comparatively costly and time-consuming, especially in larger installations. Of course, the equipment might be shut down for good, but that is hardly feasible. The remaining method is to prevent the radiation of any appreciable amount of r-f outside assigned frequencies. The F.C.C. puts it this way:

". . . A well designed shielded space or room may be expected to reduce substantially or eliminate such interference."

But "well designed" does not mean that just any shielded room is sufficient. It must be tested and certified before it may safely be depended upon to meet F.C.C. requirements. Construction of such a room or enclosure requires a considerable knowledge of the problems involved. It would probably not be wise for most diathermy equipment owners to even attempt it, for faulty construction would merely add needless expense. In addition, the cost of construction would probably be greater than that of commercially produced units.

THE DOCTOR DRAFT ACT

F. E. Wilson, M.D.*

Who Must Register Under The Doctor Draft Law? All physicians, dentists and veterinarians not members of an armed service reserve component and under 50 years of age must be registered with their local draft board. They remain liable for induction up to age 51. Men on graduating from medical school have *10 days to register and ask for deferment for a year to complete internships.* A physician must register under the doctor draft even though he has previously registered for the regular draft.

How Much Service Is Required Under The Law? Maximum service under the doctor draft is 24 months, which is required of all physicians who have had less than nine months of prior active duty. Graduated periods of service are provided for others as follows: 21 months if prior duty ranges between nine and 12 months, 18 months if prior duty ranges between 12 and 15 months, and 15 months if prior duty totals 15 or more months. The foregoing is applicable to reservists as well as registrants under the act.

In addition, *priority 2 doctors with 17 or more months' service prior to entry on current duty are classified in priority 4, and no doctor with 21 months' prior service can be called during the life of the present act,* except in time of war or national emergency declared by Congress. The law also requires release within 90 days of all men on active duty who would not have been called had the new law been in effect, but they *must apply for release.*

***Director, Washington Office of The American Medical Association.**

What Changes Are Made In The Priorities? The new law continues the four priorities, but effects two changes of importance: (A) It lowers from 21 to 17 months the amount of active duty required to move a man from priority 2 to priority 4. (B) It credits *all active duty of any nature* subsequent to September 16, 1940, except as noted in next question (the old law credited only service performed subsequent to receipt of professional degree).

(Priority 1 doctors are those who either received all or part of their professional education at government expense or received educational deferments in World War II, and who served less than 90 days on active duty. Priority 2 are those similarly educated or deferred, but who served between 90 days and 17 months — 21 months under the old law. Priority 3 are men with no military service. All other make up priority 4. Priorities 1, 2, and 3 will be called before priority 4.)

What Is The Definition Of Prior Active Duty? The law defines active duty as time spent either as *enlisted man or officer* since September 16, 1940, on (1) active duty in Army, Navy, Air Force, Marine Corps, Coast Guard, and U. S. Public Health Service, (2) non-military duty prescribed for conscientious objectors, (3) wartime military service with any World War II ally of the United States, and (4) service with the Panama Canal Health Department during World War II.

Not counted as active duty is time spent under military auspices in (1) ASTP, V-12 or similar training programs, (2) intern, residency or other postgraduate training, (3) senior student programs prior to receipt of the appropriate degree, (4) active service performed for sole purpose of undergoing a physical examination, and (5) active duty for training entered into subsequent to enactment of the law.

Who Is Eligible For Deferment? Local boards, advised by state or local medical advisory committees to Selective Service, may defer doctors for (1) essentiality to the community, (2) extreme personal hardship, (3) certain teaching posts in medical schools and (4) essential laboratory and clinical research.

Does Law Provide For Continuing Equalization Pay? The $100-a-month equalization pay is continued for all commissioned physicians and dentists (except interns) while on active duty and is extended to veterinarians.

Is It Possible To Resign Commission? Physicians obligated only under the doctor draft *are discharged* from their commissions on completion of active duty performed in carrying out doctor draft obligations, retroactive to cover all who have served a year or more since September 9, 1950 (enactment of original doctor draft law). Reservists who would be liable for doctor draft except for their membership in a reserve component *may resign* their commissions upon completion of the period of obligated service. However, permissive resignation is not extended to those who are obligated by law or contract to serve on active military duty or in training in a reserve component.

Are Aliens Eligible For A Commission? A registrant under doctor draft no longer is held ineligible for appointment as an officer on sole ground he is not a citizen of the U. S. or has not made a declaration of intent to become a citizen.

How Is Duty In U. S. Public Health Service Credited? Full credit is given for service in the commissioned corps of U. S. Public Health Service. PHS, unlike the military, may not hold a man against his will. Consequently, under the old law it would be possible for a doctor to serve in PHS for a few days, then resign and give up his commission, and move to priority 4. To forestall this, the new law requires that the Surgeon General of PHS approve termination of a commission if the time served is to be credited under the doctor draft law.

Other Points. Since the doctor draft law is part of the Selective Service Act, men covered by the law are subject to the Selective Service System up to the time they accept commissions. . . The law, as it affects doctors in service, is administered under regulations laid down by the three armed forces, within the limitations of the law. . . Selective Service has nothing to do with determining the commission or promotion to which a doctor is entitled; this is the province of the three services, which are required by law to grant commissions "commensurate with professional education, experience or ability". . . Time spent in PHS internships and residency training programs, like military programs, is not credited as active duty.

The 1953 ANNUAL MEETING

For the third consecutive year the Society held its meeting in the Hotel Sherman, Chicago. More than 3600 were registered.

For the first time the meeting ran for four days instead of three. Another innovation was increasing the meetings of the House of Delegates from two to three.



Charles S. Stevenson, Professor and Chairman, Department of Obstetrics and Gynecology, Wayne University School of Medicine, Detroit, delivered the Oration in Surgery. His topic "The Diagnosis of Occult Ectopic Pregnancy".



Perin H. Long, Professor of Medicine, College of Medicine, State University of New York at New York City gave the Oration in Medicine. His subject was "The Impact of Modern Antibacterial Therapy on the Social and Economic Aspects of the Practice of Medicine".



Top feature of the final session of the House of Delegates is the induction of the new President. Here Leo P. A. Sweeney has introduced Willis I. Lewis who has brought Mrs. Lewis to the platform to share the applause.



Mrs. Henry Christiansen of Chicago was elected President of the Woman's Auxiliary succeeding Mrs. Harlan English of Danville. For more pictures of Auxiliary activities see the next page.

Part of the speaker's table at the Annual Dinner is shown below. F. Lee Stone, who was re-elected Chairman of the Council during the meeting, The Rev. Frank M. Coyle, S.J., and Mr. Leslie Nichols of the Chicago Tribune who spoke of "The Challenge of China". Standing is Fred H. Muller, Chicago, who served as General Chairman for the meeting.





The Woman's Auxiliary

The 25th Anniversary of the Auxiliary also brought it the largest and best meeting in its history. Mrs. Nicholas G. Chester, Oak Park, (left) served as General Chairman. Brightest social event was the Silver Ball and most surprised person was Mrs. Harlan (right) when she was brought to the stage by Mrs. G. Henry Mundt, a past president, to listen to a "This-Is-Your-Life" program of story and music.

A further surprise for Mrs. English was the appearance of her mother, Mrs. H. H. Steele and brother, Mr. William Steele, of Paris. (At left and in foreground in picture below.) Others at the same table — James S. Templeton, Miss Elizabeth Hunter, Paris, and Harold M. Camp, Society Secretary.







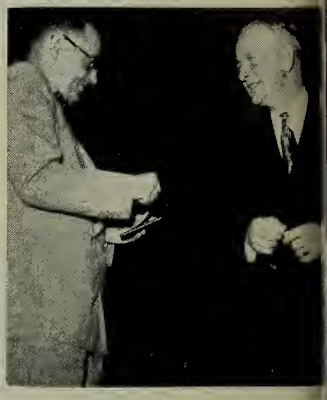


(Above right) Mrs. S. M. Hubbard, Ridge Farm, Treasurer, and Mrs. R. E. Dunlevy, Pekin, the retiring Recording Secretary talk over Auxiliary problems. (Right) H. Hoegh, Chicago, and Mr. Fred A. Seeman, Rochester, wait in foyer for party to begin.

(Left) Dr. and Mrs. Arkell M. Vaughn at the Silver Ball. He became President-Elect at this meeting.

(Left below) Mrs. Ralph Eusden, Long Beach, California, President of the Woman's Auxiliary of the A.M.A., and Dr. and Mrs. James P. Symonds, Chicago.

(Right below) Mrs. Esther Fraser, Secretary to the Chicago Medical Society, Frances Zimmer, Assistant to the Secretary of the State Society and Mrs. Leo P. A. Sweeney. Mrs. Fraser was recently honored by the Chicago Society for her 40 years service.







MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Voluntary Health Insurance on Trial!

John R. Wolff, M.D.
Chicago

On the first Tuesday in November, 1952, we witnessed the explosion of a psychological atom bomb which abruptly erased the present threat of socialized medicine.

However, at that moment the physicians of America were placed on trial. We must make voluntary health insurance work. And we must make it succeed as of now.

During the "New Deal " era of the '30's the question "shall we have health insurance" in the United States was in itself a debatable issue. The acceptance of health insurance as a part of the American way of life was acknowledged in 1938 when the house of delegates of the American Medical Association endorsed the principle of voluntary health insurance. At that time health insurance, as such was based on the principle of payments in cash to the insured individual. The amount received was dependent upon the type and length of illness and the size of the premium paid to the insurance company. The growing pains of commercial insurance of this character were tremendous. In many instances the profit motive of the insurance company seemed to play the dominant role. "Cats and dogs" companies sprang up over night and often folded over night too. Health insurance as such was not satisfactory to either the patient or the doctor.

We then witnessed the development of a nonprofit plan (Blue Cross) based on a principle of service benefits, where by paying a premium, the insured individual would receive complete hospital care. Certainly this type of care has succeeded. In spite of a beginning hazarded by a lack of sound actuarial statistics, a tremendous increase in the use of hospital care, and the ravages of inflation, Blue Cross is not only still in business, but now serves over forty-three millions of Americans. The number of people holding Blue Cross certificates has increased year by year. The 1952 election emphasized the satisfaction of the people with voluntary health insurance and erased the need of a governmental compulsory form of medical care.

We have also witnessed great improvement in the character of commercial health insurance. Today excellent health insurance covering hospital care is available to everyone.

But what about the doctor's fee? In the early days of health insurance attempts were made to include the surgeon's fee. The drama of surgery, plus the fact that the surgeon's bill is invariably in one lump sum, and that the emergency aspect of surgery often brings this bill at an inopportune time, made this aspect of medical care the first to be considered. Unfortunately the cash amounts paid to patients seemed to be based not on average fees or actuarial figures, but on the selling value of the amount as it appeared in the policy. Many commercial companies placed too many exclusions in their policies so that surgical payments, as such, never seemed to be sufficient. Obstetrical fees were later included. Again the amount was small and usually insignificant. Both patients and physicians were dissatisfied.

Fortunately leaders of organized medicine did something about this problem. County and state medical societies set up their own plans for providing insurance for the doctor's bill. Every doctor was contacted, and when fifty-one per cent of the physicians in the community agreed to participate, the plan went into action. It was readily noted that the Blue Cross organization could be expanded to become the executors of the doctors plan. The one organization could then handle both the hospital and the doctors bills at the least possible cost and on a non-profit basis. In Illinois this was accomplished under the impetus of the Chicago Medical Society. The plan — Blue Shield — became known as the Chicago Medical Service. It was soon expanded to include most of Illinois and now is called the Illinois Medical Service. Similar plans developed in Alton, Rockford and Rock Island.

Today the Blue Cross plan covers every county in the state. Millions hold these certificates. Blue Shield, starting slowly, feeling its way, today covers ninety-seven counties in this state. There are 812,359 individuals in Illinois who now hold Blue Shield certificates. As of February 28, 191,272 claims totaling over $9,754,872.00 were paid or provided for the services of 7,927 physicians in Illinois from its inception until February 28. Illinois Medical Service had assets of $5,091,554.00 on February 28.

Commercial insurance companies have recognized this competition. The "cats and dogs" are fading away. We find the major insurance companies of the nation offering excellent health insurance policies. Competition is the stimulation whereby the public reaps its greatest benefits. Certainly health insurance has become part of the American way of life.

However, none of us will be satisfied until this health insurance is available to everyone, is reasonable, and gives complete coverage for every illness. To reach this utopia we must constantly remember that Blue Cross is the baby of the hospital administrators group and that Blue Shield is *our* baby. *The future success of Blue Cross and Blue Shield is the responsibility of each doctor.* Although the administration of Blue Cross/Blue Shield is naturally supervised by financial and insurance wise experts, the policy and general ideals are set forth by us physicians. Our representatives serve on the board of governors of Blue Cross. The Blue Shield board of trustees of Illinois Medical Service is composed of physicians in its entirety. And these groups consult with you individually and collectively, for advice. Here, then, are our plans, in action. How can we help their continued success?

First of all we can do so by recognizing that these plans are our plans and that we are part of the team. We must be cogizant of the necessity of aiding in lowering the cost of care.

There is much talk about unnecessary or prolonged hospitalization, excessive use of laboratory procedures, drugs administered too long, and other such ills that increase the cost of hospital care. Each of us has merely to be honest with his patients and ourselves and such inequities will disappear. As I observe hospital care such excesses are in the extreme minority. Yet one such problem per day in each hospital in Illinois means a tremendous amount in total dollars expended.

We physicians are the leading salesmen and public relation experts for our insurance companies. We must understand the A B C's of this insurance so that we can answer our patients questions and give them proper advice. We

should know how and where to get this information. In 1953 we must know insurance as well as medicine.

Does Blue Shield give sufficient coverage of the doctor's bill? Although the allowances are based upon a compromise between the average fee charged by the average physician to the average patient and actuarial estimates, we realize that Blue Shield does not completely cover the doctors bill. Blue Shield states that their allowances neither set nor have any relation to the doctor's fee, but are based on what can be paid proportionate to the membership premiums. If the percentage of average charges paid is too small it must be corrected, if we want our plan to succeed.

Some physicians fear domination by Blue Cross or Blue Shield administrators. They feel that Blue Cross will control hospital care and that Blue Shield will set fees and control the economics of medical care. Nothing could be further from the truth. As has been stated, it is the physicians as individuals, and as a group, who will always control these plans, and govern their policies.

How can we then increase Blue Shield coverage? Only by recognizing the need of developing a policy of service benefits. Just as Blue Cross eventually must cover hospital care in its entirety, our Blue Shield must similarly cover the entire medical bill. To do this we must start slowly and feel our way. One method is take groups with limited income and offer complete medical care. The participating physicians (open to all) would agree to consider Blue Shield compensation as the only fee. Such a program is now under way in several states. We can profit by observing these pioneers, but as in all phases of medical practice, can only learn by entering this field ourselves. At the beginning applying service benefits would merely mean accepting Blue Shield allowances for the specified type of care.

Our plan administrators are doing a fine job. These responsible individuals are devoted to this phase of medical care and take pride in making voluntary insurance work. They recognize that the physician is the key to the entire problem. As such they must help the physician help himself. Each doctor must be provided with all the necessary information on health insurance problems. Discussions with county societies, specialty societies, hospital, and general practice groups are essential to good teamwork, the answering of questions, and the solving of difficulties.

Insurance forms must ask for essential information only. Prompt payment is to be encouraged. Active County Society public relations groups should be encouraged so that both plan officers and physicians will have a common meeting place. Confidence in the doctor must be continued. He is the one who determines the need of hospitalization and the care to be rendered; and it is he who determines the cost to the patient. Physicians themselves, thru their public relations committees, should do their own policing of the occasional straying doctor. The doctor needs to be informed on current insurance coverage. He should know what his plans are and are not accomplishing, what they intend to do in the future, and of needed changes in policy and specific acts. The team should function as a unit.

The patient, the recipient of all this, needs to be properly and intelligently informed in all the aspects of health insurance. Such "advertising" is not bad ethics, and when done properly, is excellent public relations. It is important that our patients recognize what present coverage they have, and what type of care is not covered.

The table of suggestions is offered as a summary of what the doctor, the plan administrator, and the patient can do to make health insurance work.

Blue Cross and Blue Shield are the doctor's answer to the problem of health insurance. To move slowly and in a practical manner, yet constantly increasing the scope, and improving the quality to more and more people is the American way. With each physician realizing his responsibility and all concerned working together voluntary health insurance cannot help but succeed, improve, and eventually solve the economics of medical care.

HOW TO HELP HEALTH INSURANCE

The Patient

1. Stay well. Have periodic health examinations.
2. Follow your doctor's advice.
3. Be insurance-wise. Ask your doctor.

4. Read your policy. Understand your insurance coverage.
5. Do not expect special favors — makes insurance cost more.
6. Expect necessary care. Avoid luxuries and frills.
7. Go to the hospital early. Go home early.
8. Keep up your premiums.

The Doctor

1. Be insurance-wise. Ask questions, seek information.
2. Teach your patients insurance facts.
3. Hospitalize for illness, not for convenience.
4. Do not cut corners to help one of your patients. You merely increase the cost to all.
5. Order necessary laboratory tests, not academic routines.
6. Be careful with drugs — they are expensive.
7. Cooperate in trying out new ideas — e.g. service benefits.
8. Work with your Medical Society to
 A. Encourage discussions of insurance problems.
 B. Organize an active liaison committee to confer with insurance executives.
 C. Air your gripes and complaints properly.

Blue Cross — Blue Shield

1. The doctor is your partner. Keep him that way.
2. Keep the doctors informed.
3. Improve the public's insurance "know-how".
4. Act promptly and justly on doctors' gripes and complaints.
5. Stimulate Medical Society discussion groups.
6. Work actively with liaison physician committees.
7. Simplify all insurance forms.
8. Pay the doctor promptly.
9. Keep down administrative costs.
10. Continue to move ahead slowly.

IMPERFORATE ANUS

In 1948 Rhoads and associates reported a one stage abdominoperineal anoplasty for newborn infants with imperforate anus, with the rectal pouch several centimeters from the perineal skin. This is an improvement over the three stage procedure consisting of colostomy, abdominoperineal anoplasty, and closure of colostomy. The selection of newborn infants with imperforate anus for this combined one stage abdominoperineal anoplasty is made on the basis of x-ray films of the infant in an inverted position with a lead marker on the anal dimple of the perineum. The distance from the air filled rectal pouch to the lead marker can be measured. If it is 1.5 cm. or less, a perineal anoplasty is the simplest method of correcting the anomaly; a greater distance prevents an adequate operation through the perineum and is an indication for the combined abdominoperineal procedure. This one step operation should not be used unless the patient is in good condition. Infants who have not been given surgical attention in the first 72 hours of life probably should be treated by the more complicated but safer three stage operation. *James Marvin Baty, M.D., et al., Pediatrics. New England J. Med. Dec. 18, 1952.*

KNOW YOUR SOCIETY

CONSTITUTIONAL COMMITTEES

In Chapter IX of the By-Laws, the list of standing committees of the Society is printed. There are seven such committees. Their duties are outlined in the various Sections.

(1) The Committee on Scientific Work is composed of the chairmen and secretaries of the 12 sections of the Society together with the president and secretary. This group meets to arrange the scientific program for each section meeting and for the general assemblies held during the annual meeting of the Society each May. The various sections authorized by the House of Delegates are:

Section on Allergy
Section on Anesthesiology
Section on Cardiovascular Disease
Section on Dermatology
Section on Eye, Ear, Nose and Throat
Section on Medicine
Section on Obstetrics and Gynecology
Section on Pathology
Section on Pediatrics
Section on Preventive Medicine and Public Health
Section on Radiology
Section on Surgery

This group meets in the fall and determines just which sections will hold independent meetings — which days they will meet — which groups will meet in joint session — when the general assemblies will be held. An executive committee is elected to be responsible for the programs before the general assemblies. Each section furnishes the name of one out-of-state guest speaker and the name of one Illinois physician to speak before the general assemblies. The executive committee schedules the speakers and times the papers. Illinois physicians are allowed 20 minutes; out-of-state speakers, 30 minutes, and the two orators (one in medicine and one in surgery) are given 45 minutes. The President's Address is usually scheduled for 30 minutes, although he is consulted relative to the amount of time he will need.

The Section officers plan their own meetings, schedule and time their own papers, and send the finished program to the secretary's office in Monmouth for publication in the Illinois Medical Journal and in the official program for distribution at the registration desk.

As the number of sections has increased it has become more and more difficult to find meeting rooms and adequate time for these groups.

During the annual meeting the Council must convene every day. The House of Delegates must meet on Tuesday, Thursday and Friday (under the new arrangements) with reference

committees scheduled for Wednesday. The Council meetings are held either at breakfast or at the noon hour. The House holds its first meeting on Tuesday afternoon at 3:00 o'clock; its second meeting on Thursday afternoon at 3:00 o'clock, and its final meeting on Friday morning at 8:30 a.m.

These problems must be faced by the Committee on Scientific Work. It is extremely difficult to plan a meeting without conflict between the business sessions and the scientific programs. When physicians are invited to speak before the assemblies, especially physicians from out-of-state, it is important that we have good attendance.

Perhaps fewer scientific papers should be scheduled. Perhaps shorter section meetings should be held. Perhaps the scientific meeting should close at noon on Friday, since attendance at the Friday assemblies during the 1953 annual meeting was very poor.

Then, to complicate the picture even more, the technical and scientific exhibits must be visited by the physicians — and many desire to attend the scientific movies. We plan half-hour recess periods every morning and every afternoon to make it possible for physicians at the meeting to contact all commercial exhibitors and to visit the scientific exhibits.

Suggestions from the members of the Illinois State Medical Society relative to the 1954 annual meeting should be sent to the secretary's office. Before the Committee on Scientific Work meets this fall, a file of suggested changes, new ideas, criticisms of past arrangements, will be prepared for the use of the committee. If you have any contribution to make, please send your letter to the secretary's office, 224 South Main Street, Monmouth.

(2) The Committee on Medical Service and Public Relations carries on its activities under the supervision and direction of the Council. Under the By-Laws this committee has charge of all matters of public policy of interest to the Society and to the state at large. The Committee disseminates information of interest to the profession; keeps both the profession and the residents of Illinois informed of medical progress in both scientific and economic fields.

The secretary of this committee, Mr. John W. Neal, is also legal counsel for the Society. During the legislative sessions in Springfield, information is sent to the entire membership of the Society to keep the members cognizant of all legal actions taken which might affect the health of the residents of Illinois. All laws pertaining to health problems are outlined for the Council at each meeting; members are kept informed of important hearings in committee, before which many of the physicians have appeared in behalf of the health and welfare of residents of Illinois.

The public relations phase of society work is handled by Mr. James C. Leary as Director of Public Relations. The continuous and important problem of press relations stems from Mr. Leary's office. Releases on all phases of Society activities are written and mailed to newspapers, news services, radio and television stations throughout the state. Publicity for postgraduate programs, for the annual meeting, for committee activities, all come from this source.

If and when any county medical society desires to develop a specialized "public relations" campaign, Mr. Leary's services are available. The maintenance of this committee, constitutional in nature, but of such importance that its activities are supervised by the Council, is one of the services membership in the Society provides.

(3) The Medico-Legal Committee provides assistance and counsel to any member of the Illinois State Medical Society against whom a malpractice suit has been filed. Under Illinois law, legal counsel cannot be provided for members by the Society. However, this Committee, with experience gained through the years, can and does interview the physician involved, or threatened with a suit, and if deemed honorable and advisable, will appear in his defense, act as medical witnesses in his behalf, and assist him to reach a satisfactory solution in his case. The committee will and does work with the insurance carrier providing the physician with his malpractice coverage.

If threatened with a malpractice suit, contact the chairman of this Committee, and request its assistance. Address your letter to: Dr. George C. Turner, 670 North Michigan Avenue, Chicago.

(4) Committee on Medical Education and Hospitals has several functions. (1) It cooperates with the state examining board in matters pertaining to medical education, (2) it makes an annual report to the House of Delegates on

the existing conditions of medical education in the state, and (3) it cooperates with the Council on Medical Education and Hospitals of the American Medical Association.

(5) The Committee on Medical Testimony was added to the list of constitutional committees several years ago. Its powers and duties are outlined clearly in the By-Laws, and were based on similar work done in Minnesota. This Committee has "authority to call in members who have been accused of giving improper testimony in court proceedings; to secure transcripts of court testimony, examine same and determine whether or not any fault exists; to censure and admonish, and if deemed advisable, report to the Department of Registration and Education of the State of Illinois any gross irregularities that may have arisen. In cases of censure or admonition, the Committee may submit its report to the Ethical Relations Committee of the county medical society for whatever action is deemed advisable."

Dr. Oscar Hawkinson has been chairman of the committee since its organization, and he and his committee personnel have worked closely with Illinois and the Chicago Bar Associations. Letters have been sent to all judges informing them of the existance and functions of this committee, and assuring them of cooperation at any time. This committee has had surprisingly little to do through the years, which speaks well for the Illinois physicians' day in court.

(6) The Committee on Medical Benevolence has functioned well since its organization in 1940. Funds in this account are spent only for the assistance of "needy members of this Society, their widows, widowers or minor children". The Committee is authorized to grant routine aid in the amount of $50.00 per month; in cases of emergency need the Council must approve the expenditure of additional funds. The fund has grown through the years, and now the allocation of $2.00 from each member's dues, pays the current costs of aid to recipients. Surplus funds are invested in government bonds, and the interest deposited in the special account.

The correspondence from physicians, their widows, etc., through the years, has exemplified the real need for this token assistance. In some cases emergency aid has been invaluable to former members of this Society or their widows who have been willing to accept this money, since at one time, their dues contributed to the general funds of the Society.

(7) The Grievance Committee functions under directives outlined in the By-Laws. It (1) cooperates with the grievance committees of component societies, where such committees exist, in the effort to adjust differences between members of the Society and the public; (2) it acts for the Society in investigating complaints and/or initiating investigations concerning professional conduct and ethical deportment, in those counties which do not have a Grievance Committee.

"In conducting such hearings, at least two members of the committee shall be assigned to conduct impartial secret hearings. At such hearings members of the Society may be ordered to appear, and lay complainants may be invited to appear, if deemed necessary.

"The investigating members should attempt, through advice and counsel, to settle minor complaints and differences of opinion, in the interest of improved public relations. If in the opinion of the investigators, fees have been excessive, they may suggest that the offending physician make some satisfactory adjustment and may warn the individual that repetition of the offense may result in disciplinary prosecution by the Society.

"If, after full investigation, the committee feels that evidence warrants, it may prefer charges of unprofessional conduct against the offender before the Ethical Relations Committee of the component society to which he belongs.

"The Committee does not have the power to try a member or to impower discipline. It can investigate; it can advise; and it can prosecute."

The committee may be asked to handle a case at the request of the county society grievance committee, or at the request of the officers of a conuty society where no grievance committee exists. Some of our county medical societies are too small to allocate personnel to various committees, and in the case of grievances, the importance of the problem makes it paramount that the state society assist in solving these cases — if and when asked to do so by the county society involved. The larger counties handle

(*Continued on page* 158)

CORRESPONDENCE



SECOND INTERNATIONAL CONGRESS OF CARDIOLOGY

The Second International Congress of Cardiology will be held in Washington, D. C., September 12-15, 1954. It will be immediately followed by the Annual Scientific Session of the American Heart Association, September 16-18, 1954. The opening session will be held in the auditorium of Constitution Hall at 10:30 A.M. on Sunday, September 12, 1954, with addresses of welcome. A reception will be given at the Mayflower Hotel at 5:00 P. M. on the same day for all Members of the Congress and their families. A banquet will be held September 15, 1954 at 7:30 P.M.

The Scientific Sessions lasting for three days will include formal papers, panel discussions, clinical pathological conferences and visits to important medical centers in Washington and Bethesda. The program will be printed in French, Spanish and English. Immediate translation of some of the papers and discussions will be made in three languages.

A series of Post-Congressional visits and conferences to at least 20 of the leading cardiac clinics in different parts of the U. S. and Canada has been arranged by special committees of local Heart Associations in the various cities.

UROLOGY AWARD

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than ten years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Waldorf-Astoria, New York, May 31-June 3, 1954.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954."

AMERICAN COLLEGE OF CHEST PHYSICIANS

The 19th Annual Meeting of the American College of Chest Physicians, held at the Hotel New Yorker, New York City, May 28-31, 1953, surpassed all previous College records for attendance at both the scientific sessions and social functions. Approximately 1,500 registered, including 1,200 members and guest

physicians, and 300 non-physician guests. The following officers were elected for the year 1953-1954. President, Alvis E. Greer, Houston, Texas; President-Elect, William A. Hudson, Detroit, Michigan; First Vice-President, James H. Stygall, Indianapolis, Indiana; Second Vice-President, Herman J. Moersch, Rochester, Minnesota; Treasurer, Charles K. Petter, Waukegan, Illinois; Assistant Treasurer, Albert H. Andrews, Jr., Chicago, Illinois; Chairman, Board of Regents, Donald R. McKay, Buffalo, New York; Historian, Carl C. Aven, Atlanta, Georgia.

Doctor Otto L. Bettag, Chicago, is Regent of the College for Illinois and Indiana. Darrell H. Trumpe, Springfield, is Governor of the College for Illinois.

The next Annual Meeting will be held in San Francisco, California, June 17-20, 1954.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 31st annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held on August 31, September 1, 2, 3 and 4, 1953 inclusive, at the Palmer House, Chicago, Ill.

Scientific and clinical sessions will be given on the days of August 31 and September 1, 2 and 3. All sessions will be open to members of medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

ANNUAL MEETING OF AMERICAN INSTITUTE OF DENTAL MEDICINE

Between three and four hundred dentists, including top dental and medical researchers, will be in attendance at the 10th Annual Meeting of the American Institute of Dental Medicine, at the Desert Inn and El Mirador, Palm Springs, California, October 25 through October 29, 1953. Advance registration, according to an announcement by Dr. Hermann Becks, Director and Founder of the Institute, indicates a capacity turn-out for the five-day study session. Included in the lecture-packed program to be discussed and analyzed at the meeting are the following subjects:

W. L. Bostick, M.D., University of California, San Francisco, California: Dynamics of inflammation; Cellular reaction to injury and The Malignant lymphoma.

A. C. Curtis, M.D., University of Michigan, Ann Arbor, Michigan: The Physiology of pigmentation in man; Cutaneous Virus Diseases; The Dentist looks at the field of dermatology.

H. B. G. Robinson, D.D.S., University of Ohio, Columbus, Ohio: The Oral Pathologist considers focal infection; Clinical aspects of intraoral ageing and recalcitrant diseases of the oral mucosa.

D. B. Scott, D.D.S., National Institutes of Health, Bethesda, Maryland: The Structure of normal dental tissues as observed under the electron microscope; Electron microscopy of carious enamel and dentin; The influence of structural variation on current histological concepts.

H. Selye, M.D., Ph.D., University of Montreal, Montreal, Canada: The alarm reaction; The general adaptation syndrome, and The role of stress and of the adaptive hormones in dental medicine.

H. Sicher, M.D., Loyola University School of Dentistry, Chicago, Illinois: Anatomic basis for the spread of dental infections; Problems of pain in dentistry and Common misconceptions in genetics.

These and other subjects along the same lines will be discussed and all Seminar lecturers will participate in a round table forum covering the application of the subjects to the practice of Dental Medicine. Applications and full information on the Seminar program may be secured by writing Miss Marion G. Lewis, Executive Secretary, 2240 Channing Way, Berkeley 4, California.

INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN NEW YORK IN SEPTEMBER

The Eighteenth Annual Congress of the United States and Canadian Sections of the International College of Surgeons will open at the Waldorf-Astoria in New York on Sunday evening, September 13, with a session open to the public on the "International Surgeons' Hall of Fame" with Dr. Richard H. Shryock, Director of the Institute of the History of Medicine of Johns Hopkins University, Baltimore, speak-

ing on "Fame in Surgery." The scientific program will open on Monday morning, September 14, with a session on "Advances in the Treatment of Cancer," with Doctors Charles S. Cameron of the American Cancer Society, Cornelius P. Rhoads of the Sloan-Kettering Institute for Cancer Research, George N. Papanicolaou of Cornell University Medical College, T. A. Watson of Cancer Services for Saskatchewan, Komei Nakayama of Chiba (Japan) University Medical School, and George J. Papayannopoulos of Athens, Greece, among the speakers. Themes for the other general assemblies will include "Teamwork in Rehabilitation"; "Advances in the Treatment of Cardiopulmonary Diseases"; "Advances in Thyroid Surgery"; Surgical Treatment of Intervertebral Disc Lesions"; "Advances in Surgery of the Stomach and Intestines"; "Advances in Surgical Treatment of Diseases of the Esophagus"; and "Advances in Vascular Surgery."

Surgical specialties which will be represented by special sessions are the following: Colo-proctology, Neurosurgery, Obstetrics and Gynecology, Occupational Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, and Urologic Surgery. There will also be five sessions for Operating Room Nurses.

A Film Forum will be held on Monday evening; a Forum on Pharmacology in Surgery on Tuesday evening; the annual banquet on Wednesday evening; and the annual Convocation on Thursday evening. All of the sessions will be held at the Waldorf-Astoria except the Convocation which will be held in Carnegie Hall.

Dr. William R. Lovelace of Albuquerque, New Mexico, is President of the United States Section of the International College of Surgeons and Dr. Douglas U. McGregor of Hamilton, Ontario, is President of the Canadian Section. Dr. Horace E. Ayers of New York is General Chairman of the 1953 Congress and serving with him as co-chairmen are Doctors Henry M. Scheer of New York and Lyon H. Appleby of Vancouver, British Columbia.

KNOW YOUR SOCIETY (Continued)

their own problems. Under the Constitution and By-Laws, the "county society is the sole judge of its members" — and this applies in this problem as well as in questions involving membership."

All constitutional committees present reports to the House of Delegates at each annual meeting. Certain committees have more contact with the Council during the fiscal year than do others — the Benevolence Committee and the Committee on Medical Service and Public Relations, for instance. Under the By-Laws, the Medico-Legal Committee should report to the Council at its January meeting, and to the House of Delegates at the annual meeting. Since the Council is empowered to act between sessions of the House, the committees which are called upon to render more service to the membership, are apt to be in closer contact with the Council (Board of Trustees) than are others.

Copies of the Constitution and By-Laws may be secured from the secretary's office — 224 South Main Street, Monmouth. To become familiar with the information contained therein, should be listed as a MUST on the agenda of all physicians interested in their medical society and its activities.

NEWS OF THE STATE



CHRISTIAN

Society News.—Dr. D. F. Ziegler, Pana, showed an AMA film on "Proctology" during a recent meeting of the Christian County Medical Society at the Taylorville Country Club. At the business meeting, Dr. N. C. Huss, Assumption, was appointed to the board of censors of the society, to fill the vacancy created by the transfer of membership of Dr. G. W. Arends, Taylor, to Sangamon County Medical Society. Dr. Arends is now a resident of Springfield. A feature of the meeting was the appointment of a gamma globulin committee composed of Drs. Ralph Seaton, Morrisonville, R. B. Siegert, Pana, and E. C. Bartelsmeyer, Taylorville.

CLINTON

Average Attendance Seventy-Six Percent.—The Clinton County Medical Society has reported an average attendance of 76 per cent at all meetings during the past year. With an approximate membership of fifteen members the society holds ten monthly meetings, vacationing during July and August. According to the Macon County Medical Society, Clinton County would like to compete with the other counties making up the Seventh Councilor District of the Illinois State Medical Society. These are Bond, Christian, Clay, Effingham, Fayette, Macon, Marion, Moultrie, Piatt and Shelby. To determine how other counties in the district would average attendance, the competition could start with the meetings beginning in September. A feature of a recent meeting of the society was the showing of picture by Dr. W. L. DuComb of his recent hunting trip.

COOK

Carroll Birch Returns to India.—Dr. Carroll L. Birch has taken a two year leave of absence as professor of medicine at the University of Illinois College of Medicine to serve as dean of the Lady Hardinge Medical College, New Delhi, India. Dr. Birch returned to the university last summer to resume her teaching position, effective September 1, after having served a year as dean of the medical college in New Delhi. She returns to India under a travel grant from the U. S. Public Health Service with the rank of reserve officer (senior surgeon) in public health.

Louis A. Weiss Hospital Dedicated.—The Louis A. Weiss Memorial Hospital, 4646 Marine Drive, was dedicated, June 28, with appropriate ceremonies. Speakers were Dr. Siegfried Strauss, president of the hospital's board of governors, his brother, Dr. Alfred Strauss, a board member, and Barnet Hodes, former corporation counsel. Mrs. Louis A. Weiss, widow of the Chicago business man and philanthropist for whom the new structure is named, was present. She made the initial gift for the $3,750,000 hospital, which was opened July 8. The T-shaped building is four stories high. The normal bed capacity of 108 beds can be expanded to one of 250 when plans for an additional four stories are completed. The hospital is affiliated with the Chicago Medical School.

Ole Nelson Retires After Forty-Two Years.—County commissioners, officials, physicians, nurses, and other associates of Dr. Ole Nelson in his forty-two years as employee and medical director of Cook

County Hospital, honored him, July 7, with a reception and tea, and presented him with an automobile commemorating his recent retirement. Mrs. Nelson was given a corsage of orchids and a bouquet of roses, the Chicago Tribune reported. Dr. Nelson had retired, June 15, following twelve years as medical director of the hospital.

Isaac Abt Honored.—On June 11 Dr. Isaac A. Abt was awarded a plaque in honor of his outstanding contributions to the science of healing sick children, the Chicago Tribune reported. The presentation was made in the nurses' residence of Michael Reese Hospital. Dr. Abt was one of the founders of the Sarah Morris Hospital for children at the hospital.

Gifts to Hektoen Institute.—The Otho S. A. Sprague Memorial Institute has given a grant of $10,000 to the Hektoen Institute for Medical Research for research in congenital heart disease (blue babies) and acquired valvular heart disease. The work will be done under the direction of Drs. Egbert H. Fell and Benjamin M. Gasul and their associates. The institute also received a gift of $10,000 from the Dr. Julian D. Levinson Foundation. This brings a total contribution of $50,000 to the institute by the foundation, which supports research in pediatric neurology for the benefit of retarded children. The fund was established in memory of Dr. Julian D. Levinson, a pediatrician, who died in 1950, at the age of 27.

Special Lectures of the Institute of Medicine.—Henry Michelson, professor of dermatology, University of Minnesota Medical School, Minneapolis, will deliver the seventh William Allen Pusey Memorial Lecture of the Institute of Medicine of Chicago, Wednesday, September 23, in the Gold Coast Room of the Drake Hotel. His subject will be "A Review and an Appraisal of the Present Knowledge of Lupus Erythematosus." The eighth Frank Billings Lecture of the Mary Holmes Nichols and Thomas Lewis Gilmer Foundation will be presented at a joint meeting of the institute with the Chicago Society of Internal Medicine at the Drake Hotel, Monday evening, October 26. The speaker will be Charles Henry Rammelkamp, Jr., Cleveland. Dr. Paul E. Steiner, Chicago, will present the fifth Richard F. Jaffe Memorial Lecture before the Institute of Medicine at the Palmer House, Monday evening, November 2.

LaRabida Inaugurates Institute on Rheumatic Fever and Observes Robert A. Black Day.—The first Annual Institute on Rheumatic Fever will be held at La Rabida Sanitarium, October 12-16, and in that period thereafter or beginning the first Monday which follows October 12. This date coincides with the anniversary period of the opening of the sanitarium on Oct. 21, 1932, Columbus Day, October 12, St. Luke's Day, October 18, and the anniversary of the "Variety Club," October 12, according to an announcement from the board of trustees.

On October 16 of this year the new Gertrude F. Pick Memorial Center for community service in rheumatic fever will be dedicated. The same day has been designated the Robert A. Black Day and a lecture in his honor will be inaugurated, the speaker to be announced later. Dr. Black had been chief of staff of LaRabida since when it was established in 1922 until a few years before his death Jan. 13, 1953. Mrs. Pick was the wife of Albert Pick Sr. who had given generously to the sanitarium.

The institute will be educational in character and will cover the subject of rheumatic fever and rheumatic heart disease. The five day session will be conducted by members of the hospital staff, together with others selected from the medical schools in the Chicago area with which the hospital is affiliated, and by invited guests. It will be directed primarily to the general practitioner or family physician and to nurses, medical social workers, occupational therapists, dentists and others with a similar interest in the subject. There will also be a scientific session, and sessions for the public, especially patients and their parents.

There will be no admission or tuition charge, but advance registration will be required for those who wish to attend the entire session. Attendance will be open to all these groups and will be limited only by the size of the building to accommodate those who attend. Visitors to individual sessions will be admitted by card on previous application. Priority for attendance will be given to Illinois physicians.

Additional information may be obtained by writing to the La Rabida Sanitarium, East Sixty-Fifth Street and South Shore Drive, Chicago 49, Illinois.

Serves on Panel.—Dr. Benjamin M. Kagan, Chairman of the Department of Pediatrics, Michael Reese Hospital of Chicago, represented pediatrics in a panel discussion on "Working Together for Healthier Mothers and Children" at the first annual meeting of the National Association for Nursing, June 22, 1953 in Cleveland, Ohio. Dr. N. J. Eastman, Obstetrician-in-Chief of Johns Hopkins Hospital, presented the obstetric point of view and Dr. H. M. Wallace of the New York City Health Department presented the public health point of view.

Woman Physician Honored.—Dr. Ottilie Zelezny Baumrucker, member of the staff of Women's and Children's Hospital, was honored, June 11, for her completion of fifty years in the practice of medicine. The honor was a feature of the annual banquet of the Rush Medical Alumni of the University of Chicago.

New Officers of Specialty Societies.—William J. Schnute was chosen president-elect of the Chicago Orthopedic Society recently, and Vernon C. Turner was installed as president. Other newly elected officers include Felix Jansey, vice president; Earl

S. Leimbacher, secretary-treasurer, and Newton C. Mead, assistant secretary.—Newly elected officers of the Chicago Urological Society are Andrew McNally, president; John W. Ferrin, vice president, and Joseph H. Kiefer, secretary-treasurer.—At the May 25 meeting of the Chicago Society of Internal Medicine, the following officers were elected: Richard B. Capps, president; Arthur R. Colwell, vice president; Edwin N. Irons, secretary-treasurer, and Howard L. Alt, Frank B. Kelly and Lowell R. Coggeshall, executive committee.—The Illinois Chapter of the American College of Chest Physicians recently chose the following officers: Abel Froman, president; Clifton F. Hall, Springfield, vice president, and Albert H. Andrews Jr., secretary. Dr. Andrews was also recently elected assistant treasurer of the American College of Chest Physicians.—Will F. Lyon became president of the Chicago Society of Industrial Medicine and Surgery at its annual meeting, June 22, and Donald Knowles, vice president. Charles Drueck continues as secretary-treasurer. Speakers at the meeting were Max S. Sadove on "Anesthesia and Analgesia for the Emergency Patients", and Edward C. Holmblad, Highlights of the Los Angeles Industrial Health Conference.

Faculty Members Honored.—Five members of the College of Medicine faculty were honored at commencement exercises of the University of Illinois Chicago Professional Colleges held on June 18.

Emeritus status was awarded to four who will retire September 1, 1953. They are Drs. Thomas Cottrell, Georgiana Theobald, Michael H. Ebert, and Earle B. Fowler. Dr. Sidney A. Portis has resigned as clinical associate professor of medicine to enter private practice in California.

Dr. Cottrell, who received his doctor of medicine degree from Loyola University in 1911, has been a member of the College of Medicine faculty since 1941. Previously he had been associated with the faculty of Rush Medical College since 1920. Dr. Cottrell has retired as a clinical assistant professor of urology.

Dr. Ebert also joined the College of Medicine as clinical professor of dermatology when Rush Medical College became affiliated with the University of Illinois in 1941. He had been at Rush Medical College since 1945. He received his doctor of medicine degree from Rush in 1917.

Dr. Fowler was appointed clinical associate professor of ophthalmology in 1941 from Rush Medical College. Dr. Fowler was awarded the doctor of medicine degree by Rush in 1910.

Dr. Theobald has retired as clinical associate professor of ophthalmology. Dr. Theobald received the doctor of medicine degree from the College of Physicians and Surgeons at the University of Illinois in 1906.

Dr. Portis has been associated with the University since 1941, and Rush Medical College since 1920. He is a 1918 graduate of Rush Medical College.

The Raymond Allen Awards.—Raymond B. Allen Instructorship Awards have been presented to five faculty members by students at the University of Illinois College of Medicine. Recipients of keys in the form of "Golden Apples" from the senior class were Dr. Heyworth N. Sanford, clinical professor of pediatrics, and Dr. Frank B. Kelly, clinical professor of medicine. The junior class selected Drs. Sanford, and Norman B. Roberg, clinical assistant professor of medicine. Dr. Theodore R. Sherrod, assistant professor of pharmacology, received a key from the sophomore class, and Dr. Faith LaVelle, instructor in anatomy, received the award from members of the freshmen class. The awards are designed to honor excellency in individual instructorship rendered by faculty to students.

GREEN

Gamma Globulin Topic of Meeting.—Dr. Leonard Schuman, head of the department of epidemiology of the Illinois State Department of Public Health, addressed the members of the Greene County Medical Society at its meeting, June 9, on the distribution of gamma globulin. Guests of the society included the executive committee of the Greene County chapter of the National Foundation for Infantile Paralysis.

MADISON

Annual Outing.—Members of the Madison County Medical Society were guests of Dr. Groves B. Smith, Medical Director and Superintendent of Beverly Farm, at a buffet supper recently. A fireworks display featured the occasion. The affair is an annual affair at Beverly Farm with Dr. Smith as host. Dr. Francis J. Burns, instructor in surgery, St. Louis University School of Medicine, addressed a recent meeting of the society on "Common Rectal Diseases."

WINNEBAGO

Physicians and Lawyers Hold Joint Picnic.—The Winnebago County Medical Society and the Winnebago Bar Association held their annual picnic June 17 at the residence of Dr. Maurice Rogers, Spring Brook Road, Rockford. The day was highlighted with games and a smörgasbord dinner.

Three Day Polio Clinic.—A three day medical clinic, aimed at presenting the most recent developments in combating and treating polio, was held in Rockford recently. Two days in June were given over to the clinic and the third day in July. The clinic was held by the Winnebago County chapter of the National Foundation for Infantile Paralysis in cooperation with the Winnebago County Medical Society.

GENERAL

College of Surgeons to Meet in Chicago.—The thirty-ninth annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 5-9, with headquarters at the Conrad Hilton Hotel. Surgical techniques and new developments

in surgery will be presented in formal scientific papers, panel discussions, symposiums, postgraduate courses, surgical forums, medical motion pictures, color television and exhibits. Dr. Thomas C. Douglass, associate professor of surgery, Northwestern University Medical School, is chairman of the Chicago Committee on Arrangements.

State Health Office Issues Annual Report.—The thirty-fifth annual report of the Illinois Department of Public Health has just been released covering the year ended June 30, 1952. The department is one of thirteen authorized by the Civil Administrative Code and is made up of seven divisions, each responsible to the director, who is Dr. Roland R. Cross. These divisions are preventive medicine, dental health, local health services, sanitary engineering, laboratories, hospitals and chronic illness and general administration. Within each division is a varying number of bureaus, each responsible for a specific aspect of the division program. Field services for the state department of public health are carried out by five regional health offices, located at Aurora, Rock Island, Champaign, Springfield and Carbondale.

The report just issued deals with such topics as brucellosis, cancer, civil defense, dental health, biologics and drugs, heart disease, hospital construction, infant diarrhea, insect and rodent control, immunization, laboratories, milk, nutrition, narcotics addicts, nursing homes, polio, premature infants, stream pollution, swimming pools, statistics, school health, tuberculosis, venereal disease and water supply. A discussion of budget and organization are also included in the report.

Advisers to Department of Welfare.—Dr. Roy R. Grinker and Dr. Ralph W. Gerard, both of Chicago, were recently appointed consultants in psychiatry and research, respectively, to the Illinois Department of Public Welfare. The appointments were made by Dr. Otto L. Bettag, director of the department.

Your Doctor Speaks over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks" over FM Station WFJL:

Salvatore A. Motto, medical consultant, St. Mary of Nazareth Hospital, June 18, Acute and Chronic Pancreatitis.

George Vlasis, adjunct obstetrician, Chicago Maternity Center, June 25, Prenatal Care.

Alan R. Feinberg, instructor in medicine, Northwestern University Medical School, July 2, Hay Fever and Asthma.

Jerome T. Paul, assistant professor of medicine, University of Illinois College of Medicine, July 9, Diabetes.

"Your Doctor Speaks" is sponsored by the **Educational Committee** of the **Illinois State Medical Society** in cooperation with **WFJL.**

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

John B. O'Donoghue, Chicago, Bureau County Medical Society in St. Margaret's Hospital, Spring Valley, September 8, on Proper Treatment of Complications of Duodenal Ulcer.

Armand J. Mauzey, Chicago, Henry County Medical Society in the Congregational Church, Geneseo, September 9, on Diagnosis and Treatment of Endometriosis.

Carlo S. Scuderi, Chicago, Knox County Medical Society at the Galesburg Club, Galesburg, September 17, on Backache: Its Diagnosis and Treatment.

William E. Adams, Chicago, Iowa-Illinois Central District Medical Association at the Plantation, Rock Island, September 23, on Significance of Hemoptysis in Pulmonary Disease.

DEATHS

James Joseph Collins, Galena, who graduated at Marquette University School of Medicine, Milwaukee, in 1935, died in Mercy Hospital, Dubuque, Iowa, April 2, aged 47, of malignant hypertension.

John Bertram Fitzgerald, Chicago, who graduated at Northwestern University Medical School in 1928, died April 26, aged 54. He was associate in the department of surgery at his alma mater, and a specialist certified by the American Board of Surgery.

Edwin M. Harrison, Chicago, who graduated at Bennett Medical College in 1912, died June 24, aged 72. He served on the staffs of St. Elizabeth's and Illinois Masonic Hospitals.

James Tosuke Higa, Chicago, who graduated at the College of Medical Evangelists, Loma Linda and Los Angeles, in 1943, died April 29, aged 41, of cerebral hemorrhage. He was affiliated with the Alexian Brothers, Cuneo, and the American Hospitals.

Frederick Hiller, Evanston, who graduated at Ludwig-Maximilians-Universität Medizinische Fakultät, München, Bavaria, in 1917, died June 28, aged 62. He was associate professor of nervous and mental diseases at Northwestern University Medical School, a member of the attending staff at Wesley Memorial Hospital, and on the courtesy staff of Evanston, St. Francis and Passavant Hospitals.

Archibald Magruder Keith, Greenville, who graduated at Kansas City Hahnemann Medical College in 1907, and St. Louis College of Physicians and Surgeons in 1908, died in the Mark Greer Hospital, Vandalia, March 9, aged 81.

Earl Dewey Kimbrell, Chicago, who graduated at Northwestern University Medical School in 1931, died April 27, aged 52, of coronary occlusion. He served with the Indian Service.

Joseph Joessel Lebowitz, Chicago, who graduated at Northwestern University Medical School in 1914, died May 13, aged 62, of coronary thrombosis. He served as an associate in the department of surgery at his alma mater; he was president of the South Chicago Community Hospital.

Lawrence Webb Leslie, Chicago, who graduated at Northwestern University Medical School in 1948, died March 27, aged 28. He served during World War II.

George W. Mahoney, retired, Wilmette, who graduated at Bellevue Hospital Medical College, New York, in 1888, died June 11, aged 92. He was a specialist certified by the American Board of Ophthalmology.

Thomas Edward Meany, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1909, died March 21, aged 68, of cerebral hemorrhage and leukemia. He was formerly on the faculty of Loyola University School of Medicine.

John W. Nuzum, Chicago, who graduated at Rush Medical College in 1914, died June 14, aged 62. He was a member of the attending staff at Augustana Hospital.

Roswell T. Pettit, Ottawa, who graduated at Rush Medical College in 1913, died June 27, aged 68, of coronary disease. He was a specialist certified by the American Board of Radiology.

Brown Pusey, retired, Chicago, who graduated at the University of Pennsylvania School of Medicine in 1892, died July 4, aged 83. He was professor emeritus of ophthalmology at Northwestern University Medical School.

Lew Selig, Chicago, who graduated at Chicago Medical School in 1922, died April 15, aged 69, of cancer.

Edwin B. Wunderlich, Chicago, who graduated at Dearborn Medical College, Chicago, in 1906, died July 5, aged 75. He was a member of the attending staff at Lutheran Deaconess Hospital.

MARRIAGES

Edson F. Fowler, Evanston, to Helen Sironia Pearson, in June.

HOME SERVICE FOR THE ILL

Slightly more than two years ago, the Essex County Service for the Chronically Ill, a project of the Essex County Medical Society, instituted a Homemaker Service as a pilot study for homes in which there are long-term or disabled patients. This is the only homemaker program in the nation designed exclusively for persons suffering from chronic diseases. We have provided over 10,000 hours of service and we find to our gratification that patients, families, physicians, and the voluntary and official agencies are equally enthusiastic about our plan. At present we have a fulltime supervisor and 32 homemakers on the staff. Homemaker service includes marketing, doing errands, preparation of meals for patient and family, light routine house-cleaning, and working with the family to maintain a well organized household despite the presence of chronic illness. *Mrs. Asher Yaguda, Homemaker Service. Pub. Health News (New Jersey), March 1953.*

No mass screening effort is complete until every person examined has received a final diagnosis and is assigned to a definite category for follow-up and treatment. Arthur C. Christie, M.D., J.A.V.M.A., January 10, 1953.

Tuberculosis is still the leading cause of death among young adults in the most fruitful years of their lives. It is not time for a change in the energy and relentlessness with which the disease has been attacked. Thomas Parran, M.D., Bulletin of the Pennsylvania TB & Health Society, February, 1953.

The conquest of tuberculosis in our country will be expedited by concentration on those measures which have been most productive in the past decades. These are early case finding, prompt and adequate treatment, including the newer surgical procedures, and effective medical follow-up and rehabilitation of arrested cases. Vigorous efforts along these lines are absolutely essential but not only for the welfare of those with the disease but also for the protection of those who might otherwise become infected. The detection and isolation of infectious cases are the most effective curbs to the spread of the disease. Louis I. Dublin, A 40 Year Campaign Against Tuberculosis, Metropolitan Life Insurance Company, 1952.

HOUSE OF DELEGATES



SECOND SESSION OF THE HOUSE OF DELEGATES

1953 Annual Meeting — May 21, 1953

The second session of the House of Delegates during the 1953 annual meeting was called to order by the President, Leo P. A. Sweeney, at 3:15 p.m., May 21. Harlan English as chairman of the Committee on Credentials, reported that 121 delegates, 17 officers and members of the Council had registered for this session. He moved that this group constitute the voting strength for the meeting. Second by W. E. Kittler, Rochelle, and carried.

President Sweeney stated that if there were no objections, the attendance slips would constitute the roll call for the meeting.

Minutes for the previous session were read by the secretary and were approved.

1955 *and* 1956 *Annual Meetings*

The President stated that the next order of business was the selection of a meeting place for the 1955 and 1956 annual meetings. He asked the secretary to discuss the matter. The secretary stated that no city in Illinois outside of Chicago could furnish adequate facilities for the meetings. In Chicago, it was his opinion, that only two hotels had sufficient meeting rooms to care for the needs. The Sherman has more, and remains the only hotel that can take care of the state society and the Woman's Auxiliary under one roof. Arrangements must be made for the 12 scientific sections in addition to the large number of exhibit booths for the scientific and technical exhibits. The House of Delegates last year named the Sherman as the meeting place for 1954; there is a definite advantage to arranging the place for the annual meeting two or three years in advance. If the House of Delegates does not choose to make the selection, it can be left to the decision of the Council. W. E. Kittler, Rochelle, moved that the meetings in 1955 and 1956 be held at the Sherman. Second by E. E. Davis of Avon. Frank H. Fowler, Chicago, believed it better to leave the decision to the discretion of the Council. Fowler moved as an amendment to the motion, that the selection of the meeting places for 1955 and 1956 be left to the discretion of the Council. Second by J. Mather Pfeiffenberger, Alton, and carried. The motion as amended was then voted upon and was carried.

Death of L. J. Hughes

President Sweeney called attention to the notice in the morning paper announcing the death of Lawrence J. Hughes of Elgin, for a number of years a member of the Council from the First District. Secretary Camp reported that at the meeting of the Council that morning, it was called to their attention, and instructions had been given him to send a telegram of sympathy and flowers for the funeral. This order had been carried out.

Guests at session

The President introduced George F. Lull, Secretary and General Manager of the American Medical Association; Mr. H. W. Jones, representative of the American Medical Education Foundation, and the three official representatives of the Student American Medical Association, Herbert Sohn, Burton Blackman and Herbert Finkelstone.

Candidates for Emeritus Membership

There being no unfinished business on the agenda, the secretary read the list of candidates for Emeritus, Past Service and Retired membership, all of whom had been recommended by their component societies and found to be eligible for the respective classifications.

Motion by G. Henry Mundt of Chicago, second by Harlan English, Danville, that they be so elected. Motion carried.

Reference Committee reports

President Sweeney then called for reports from those Reference Committees which had reports ready for presentation.

G. Henry Mundt, Chicago, as chairman of the COMMITTEE ON REPORTS OF OFFICERS, gave the committee's report. The committee commented favorably on the observations of the president concerning a close liaison between physicians and legislators, both state and national. The committee likewise favored a continuance of the physicians participating freely in the affairs of their communities. The committee noted the favorable comments of the president on the activities of the Council and its chairman, F. Lee Stone, the secretary, Harold M. Camp, and his executive assistant, Mrs. Frances C. Zimmer. Also favorable comments were made concerning his immediate predecessor, C. Paul White, who was president of the Society a year ago.

The work of the Postgraduate Education Committee and the Committee on Medical Service and Public Relations, as discussed by the President, was approved by the committee. The committee was happy to see the work of Doctor Hellmuth and Doctor Hopkins as chairmen of the Committees, properly recognized.

The committee assured the president that he had conducted his office with honor and dignity. He will be a welcome addition to the growing list of able past presidents.

Motion by Mundt that this portion of the report be approved. Second by Walter Bornemeier of Chicago, and carried.

The committee read with pleasure the report of the president elect, Willis I. Lewis of Herrin. They noted his efforts and plans to prepare himself for the high office of president during the next fiscal year. Motion by Mundt that this portion of the report be approved. Second by Andy Hall, Mt. Vernon, and carried.

Physician Placement Service

Chairman Mundt reported on the annual report of the secretary-treasurer, Harold M. Camp. The committee made favorable comments on that portion of the report relative to the physician placement service which has been operated in the secretary's office for the past 11 years. The committee believed the secretary and his staff have investigated this matter in all of its many phases. Mundt asked approval of the House to permit the secretary to discuss the reported shortage of physicians in Illinois. Permission was granted.

The secretary told of the plans used in his office in the efforts to get physicians into the rural areas where they are more urgently needed. He told of the gradual improvement in the cooperation of lay groups in rural areas in making better facilities available for physicians willing to locate there. Several specific examples were given. The secretary told of one rural area with which he was quite familiar where 50 years ago there were two physicians in one small town and within a radius of ten miles there were 16 physicians, all of whom were very busy. Today in that same area there are two physicians, none in the small town, but the two practitioners cover more territory and see more patients daily than did the 16 practitioners half a century ago. No one in the area is wanting medical care and unable to get it, and with but little loss of time.

The secretary told of small towns where they have had a physician for many years, and see no reason why they should not have a young man come in as previous physicians always had plenty to do while practicing there. He told of the investigations made of the individual communities in the effort to determine the actual need and whether or not it might be considered urgent. Too often the individual asking for a physician has something to sell or rent, which seems to be the paramount reason for the request.

The placement service in the secretary's office dates back to the beginning of the Procurement and Assignment Service for Physicians early in World War II, when that function was one of the duties of the state chairman and his personnel. Mrs. Jane Swanson has been in charge of the service in the office during all this time, and she devotes a great deal of her time to this work. Questionnaires are sent to physicians seeking locations as well as to communities asking for a physician. We try to find the number of physicians serving the area, the distance from the town to the nearest physician, information about the town itself, population, inducements which may aid in attracting a physician, houses and office facilities available, the road system, primary and secondary, schools, churches, etc. Then we send a form to the physician asking for information about himself. Occasionally we learn that the physician has had several locations within a relative short period of time and we try to ascertain why he moves so frequently. We try to determine whether or not the physician would be satisfied to live in a small town and become part of the community. There is no doubt that in most of these small places today, a physician willing to work can do a tremendous amount of work in these rural areas.

More recently we have insisted that many of these small places offer inducements to procure a good physician by putting a fund in a bank which will be available to the doctor in getting started in his practice. One community recently informed us that they had the sum of $10,000.00 from which the physician could draw to get started, and within a short time they had a physician. Other places informed us that they had a good home and office ready for the doctor which would be rent free until he was able to pay. It is surprising how many communities are willing to cooperate to get a resident physician.

Hospital privileges are also assured at local or nearby towns. We have a list of more than 100

physicians who have asked for information. We send them monthly letters and mimeographed lists of communities seeking a physician with factual data concerning each of them.

Although it is generally known that there is mal distribution of physicians in most states, more than are perhaps needed in urban centers, yet we have failed to hear of a single instance anywhere in Illinois of any person needing medical services who was unable to find a physician within a short time.

Under the Hill Burton Act many new hospitals have been constructed in Illinois, with more in the southern end of the state where the need was greatest. Likewise with private capital, a number of new hospitals have been built, while others have been enlarged during the past three years. It is our opinion that there is not actually a shortage of physicians in the state of Illinois.

Doctor Mundt continued with the reading of his committee report referring to the secretary's statement concerning the hospital situation in Illinois. He stated that his committee agreed with the secretary in his implication that the so called shortage of physicians in Illinois is mythical. Mundt commented on the secretary's statements concerning the work of the Woman's Auxiliary and especially that portion relative to their activities in procuring funds for the Medical Benevolence fund. The committee commended the portion of the report referring to medical public relations, and also the Secretary's Newsletter being sent out monthly to an increasing list of members who have asked to be on the mailing list.

The committee approved the three meetings of the House of Delegates referred to in the secretary's report and was pleased to note the financial report of the treasurer showed the financial solvency of the Society. Mundt moved, second by Kittler, that this portion of the report be approved. Motion carried.

Motion, Mundt, second Pfeiffenberger, that the report as a whole be approved. Motion carried. The report was signed by Tom Kirkwood, Harry J. Dooley, Harry Mantz and G. Henry Mundt, chairman.

A.M.E.F. Awards Presented

President Sweeney called upon Edwin S. Hamilton. Hamilton stated that it was his privilege to do something that had never been done in the House of Delegates — to present a member of the Society a citation for special interest in the American Medical Education Foundation. He asked Mather Pfeiffenberger to come to the platform, then stated: "Doctor Pfeiffenberger, for many years you have been an outstanding member of the Illinois State Medical Society. Twenty-five years ago you were president of the Society, and you have never lost interest in its activities. You have shown your interest in medicine by sending two or three of your children to medical schools. Outside of that, you have seen fit to make substantial donations to the American Medical Education Foundation. On behalf of the American Medical Association I wish to make this citation for outstanding service to the American Medical Education Foundation, of which I am a director, and there is no one to whom I would rather make this presentation."

Dr. Pfeiffenberger: "This is a complete surprise to me, and I hardly know what to say. I do not want to be critical, but Mrs. Pfeiffenberger gave this contribution just as much as I did. When I made this donation, it was in her name and mine. She has been a wonderful helpmate and the mother of our seven children. I thank the good Lord for every day I live with her. Thank you."

Doctor Hamilton then asked Eugene T. McEnery, president of the Chicago Medical Society, to come to the platform and stated: "The Chicago Medical Society in 1952, gave the American Medical Education Foundation the sum of $25,000.00 This was one of the most outstanding contributions for that year. It is my privilege to present an award of merit from the Directors of the American Medical Education Foundation to the president of the Chicago Medical Society for its generous donation." Dr. McEnery stated that this was an unexpected and pleasant surprise, and he "accepted the award on behalf of the Chicago Medical Society". He stated that "we need something like this Foundation to keep medicine going".

Doctor Sweeney said it was very gratifying to have members of this Society receive these awards.

Sweeney then called upon Pliny R. Blodgett to present the report of the REFERENCE COMMITTEE ON REPORTS OF COUNCILORS.

Blodgett stated that the committee as a whole carefully studied each of the reports made by the individual councilors, as printed in the handbook, and talked to many of the individual Councilors. They were impressed with the industrious manner as well as the wisdom of this group which actually handles the affairs of the Illinois State Medical Society. They have all done a wonderful job, and are entitled to the thanks of every member of the Society. The Committee was impressed with the fine public relations work, particularly in the downstate districts. In the postgraduate activities it was evident that the best work was done and the greatest interest evidenced where there were active local committees. The committee had nothing but commendation for the manner in which each councilor had discharged the duties intrusted to him.

The report was signed by J. K. Rosson, M. D. Murfin, Lorne Mason and Pliny R. Blodgett, chairman. Motion by Blodgett, seconded by Harry Mantz, that the report be adopted. Motion carried.

The president called for the report of the reference committee on REPORTS OF STANDING COMMITTEES. Klein first reported on the report of the *Committee on Medical Service and Public Relations*, stating that they were impressed by the wide scope and great amount of detail involved in dealing with the many problems requiring the attention of the committee. They commented on the close coordination and team work between the offices of Mr. Neal and

Mr. Leary in carrying on the committee's activities. They agreed with the committee in its emphasis of the importance of promoting good public relations in a continuous effort to strengthen our defenses against the inroads of socialism. They believed organized medicine had assumed a more favorable position than ever before. The committee approved the efforts to awaken the interests of all members of the Society in proper medical public relations, and agreed that good public relations should begin in the doctor's office. Klein stated that his reference committee approved the efforts of Mr. Neal, the legal representative, who remained in constant touch with all legislative matters at the state capitol.

The reference committee joined with this and other committees, in a feeling of satisfaction in the selection of Dr. James Scott Templeton of Pinckneyville as the outstanding general practitioner of Illinois for the current year.

The committee report concerning the exhibit at the Illinois State Fair was heartily approved as a commendable project. Comments were made also on the Illinois Interprofessional Council, and low cost voluntary prepayment insurance. Klein moved that this portion of the report be approved, seconded by Fred H. Muller, and carried.

The report of the *Committee on Archives* was reviewed, and Klein stated that this committee has endeavored to do a good job and was deserving of our continued interest and assistance to carry out his program. Klein moved that this portion of the report be approved; seconded by Pfeiffenberger, and carried.

The report of the *Committee on Medical Education and Hospitals* was found to be interesting and informative. The detailed summary of the problems facing medical schools was worthy of the attention of all members. The current plight of the medical schools with the ever mounting cost of medical education, and the increasing difficulty of maintaining financial stability, is a challenge which must be met by organized medicine. The reference committee was in complete agreement that the medical profession has an obligation to try to find a solution to this perplexing problem. Academic independence in medical education can and should be preserved.

The importance of insurance in connection with hospitalization was discussed with the ever increasing utilization of hospital facilities. Comments were made relative to the present nursing problem as well as the roll of the hospitals in teaching future physicians and nurses. Klein moved that this portion of the report be approved; seconded by Harry Mantz, and carried.

The report of the *Committee on Medical Benevolence* was reviewed. It was recommended that every member should give it serious thought. They believed this one of the most worth while projects undertaken by the Society, and gave full credit to the late John S. Nagel for establishing the committee and its fine work. The cooperation of the Woman's Auxiliary was commended highly. The committee was pleased to note the present financial condition of the Benevolence Fund. Klein moved this portion of the report be approved; seconded by E. S. Hamilton, and carried.

The report of the *Grievance Committee* was most gratifying. Few cases were referred to the committee during the past year, and the manner in which these were handled was a credit to the committee. Klein moved that this portion of the report be approved, seconded by F. H. Muller, and carried.

Klein then moved that the report as a whole be approved, seconded by Hamilton and carried. The report was signed by Paul Blackburn, Norman Sheehe, John R. Wolf, and Bernard Klein as chairman.

Klein stated that two resolutions were referred to his committee by the president: (1) the resolution presented from Winnebago County asking for a special legislative committee. After reviewing the resolution, and conferring with the legal counsel, Mr. John W. Neal, the committee believed that such a committee would not serve a useful purpose at this time. It was pointed out that legislative problems were in the hands of the Committee on Medical Service and Public Relations, and that this committee did not approve the resolution as the legislative problems are already well handled. The reference committee did not approve the resolution. Klein moved that this resolution not be approved, seconded by Hamilton and carried.

(2) The resolution submitted by the Clark County Medical Society and presented by Dr. Johnson, was considered. It was the opinion of the Reference committee that to carry out the intent and purpose of this resolution would not be to the best interests of the Society due to various reasons. The committee also pointed out that the state society was well represented at the state capitol by the secretary of the Committee on Medical Service and Public Relations. Klein moved, seconded by Scatliff, that the resolution be not approved. John E. Bohan, delegate from Warren County Medical Society, discussed the resolution and believed that the voting record of legislators should be published, or at least be made available to the members of the Society. John W. Neal was asked to discuss the resolution and tell how the Society is represented at the State capitol during legislative sessions. Neal told briefly how the legislative activities of this organization are carried on. Briefly he discussed several bills introduced during the current legislative session, what they would mean if they had passed, then he told of the disposition of some and the current standing of others. He stated that he received advice from the committee which he represents, which in turn, gets instructions from the Council. Klein stated that his reference committee did not believe that the Illinois Medical Journal was the proper place for political activity, and that the committee did not believe it advisable to publish the voting record on each of the bills in which the Society is interested. A number were present to discuss this before the refer-

ence committee, and the committee recommended that it not be adopted. Sweeney put the motion, and the resolution was not adopted by unanimous action.

REFERENCE COMMITTEE "A" — James H. Hutton, chairman, then reported. Hutton referred to the report of the *Educational Committee,* stating that the chairman of this committee came before the reference committee and told in detail the functions of his committee, and what he considered the value of its radio, television programs, and the release, "Health Talk". Hutton stated that his committee recommended the approval of the report, and he so moved, seconded by Fred H. Muller, that this portion of the report be approved. Motion carried.

The report of the *Postgraduate Education Committee* was reviewed. The chairman, George A. Hellmuth, and members of his committee appeared at the hearing, explaining in detail the plans used during the past year in conducting post graduate conferences in Illinois. He believed there was a great need for a survey of postgraduate education in the state. This has been discussed with other organizations which are interested in such a survey and have assured us of their willingness to offer financial assistance. The reference committee recommended that the House approve this report and support the committee request for such a survey. Moved adoption of this portion of the report (Hutton), seconded by Fred H. Muller, and carried.

The *Scientific Service Committee* report was discussed. The reference committee commended the committee for its work during the past year, and congratulated the chairman and committee personnel on the high caliber of the speakers provided. Hutton moved, seconded by Mundt, that this portion of the report be approved. Motion carried.

The *Fifty Year Club* report was reviewed by the reference committee. The committee was commended for its activities, and the hope was expressed that its membership would continue to increase. Hutton moved, seconded by Harry Mantz, that this portion of the report be approved. Motion carried.

The committee reviewed the report of the *Committee on Medical Economics,* noting that this committee has had articles in all but two issues of the Illinois Medical Journal during the past year. One member appeared before the reference committee and expressed the hope that the committee would discuss retirement plans and how to keep young physicians in general practice. Hutton moved, seconded by Harlan English, that this portion of the report be approved. Motion carried.

The Committee on Physical Medicine and Rehabilitation was commended first for the brevity of its report, although the reference committee realized that this bore a very small relation to the amount of work which was actually done. Hutton moved, seconded by Fred H. Muller, that this portion of the report be approved. Motion carried.

Hutton stated that some resolutions had been referred to the committee: (1) a resolution introduced by E. H. Weld, Rockford, which had not been submitted to nor approved by the Winnebago County Medical Society. The reference committee recommended that it be not approved. Hutton moved, seconded by Andy Hall, that this be not approved. Motion carried.

(2) Resolution from Winnebago County Medical Society (#10, introduced at the first meeting of the House of Delegates). The committee was divided in its opinion regarding this resolution. The majority favored its adoption by the House. The minority was equally opposed to that action. Hutton moved that the minority report be substituted for the majority report and the resolution be not adopted. Seconded by Walter Bornemeier, Chicago.

Discussion. Kittler could not see why the minority report should be adopted when the majority of members on the reference committee approved the majority recommendation that it be approved. Weld stated that they had gone over the resolution carefully. They opposed it a year ago because they felt that the membership of the different counties had not been sufficiently informed so they could instruct their delegates how to vote. Weld's society was surprised that no other state society had adopted a similar procedure. He doubted the wisdom of this society continuing to pay the assessment when other states have not done so. He stated that New York has adopted an assessment which is voluntary so that members can pay $10.00 with their annual dues if they so desire, but it is not compulsory. Weld stated that the membership of Winnebago County does not object to the amount, but the manner in which it has been assessed. They would object just as strenuously if the amount had been $2.00 instead of $20.00. Weld wondered if the members wanted to continue to be guinea pigs for the rest of the country, or if they wanted to pay as they do in some other states, on a voluntary basis.

White continued the discussion. He said it was his opinion a year ago that it was the conscience of this House of Delegates that we owe something to our medical schools which today are having a hard time to get along. Last year at the meeting of the House, the matter was well presented and enough time was given for opinions and discussions from the entire membership. It was carried by a large majority vote. At that time some delegates wanted to make the increase in dues from $10.00 to $100.00 annually. He believed that each of us has an obligation to the school where he received training and he believed that the recommendation of the chairman of the Reference committee was entirely logical.

Bornemeier supported the minority report which was before the House. He stated that it is very important that we support the American Medical Education Foundation. He did not approve support whereby one physician might donate $1,000.00 and another $500.00 and many others nothing at all. He believed it best that every member give support by paying $20.00 per annum right down the line as we have done during the current year. There have been but few complaints and the plan has been working nicely.

Hamilton discussed the motion stating that during 1952 members of this Society gave $37,000.00 to the American Medical Education Foundation, but of this amount the Chicago Medical Society gave $25,000.00; two individual members gave $1,000.00 each, and only $15,000.00 came from the other 9,700 members. Although admiring Dr. Weld, Hamilton could not agree with his logic. We are in the experimental stage in helping medical education. We are trying to raise a sizeable sum of money. The state society which gave $100,000.00 from its treasury has not duplicated this action. Illinois is trying to lead in a campaign to show that money can be raised by small amounts from each member. Hamilton has heard that some other states plan to adopt a procedure somewhat like the Illinois plan. Approximately $140,000.00 has been turned over to the American Medical Education Foundation during the first five months of this year from the state society, and he recommended that this plan be continued for the next year.

Dr. Maloney of Rockford, believed that all could pay more, but it was the method of payment to which they objected. Some do not like to have things like this crammed down their throats. He stated that they were against this method and he hoped that the majority report of the reference committee would be approved.

Dr. Maloney of Princeton discussed the motion and asked if under the present method if this were a charitable donation. He asked that the society leave it as dues as it is handled very efficiently this way. In his own Bureau County Society, they even collect the cost of meals for dinner meetings with their annual dues, which they believe is more efficient than any other procedure.

Kenneth Schnepp, Springfield, referred to the action taken a year ago which won by an overwhelming majority, and believed it advisable to continue this procedure for the next year.

Hedge stated that the most important question before the House was whether the minority or majority report should be adopted. Why not put it up to the House, as the House of Delegates is the final organization and on it will depend the action. The president asked Hutton to answer the question. Hutton said that as far as moving the adoption of the minority report, which meant that the resolution be not adopted, the members of the majority would accept this. It does not make the slightest difference whether you vote on the majority or the minority report. To defeat one, would be to accept the other. Kittler asked for an opinion from the parliamentarian. Furey stated that Hutton had put this fairly; he is bound to report the action of his reference committee.

The president stated that the question was called for: an "aye" vote meant that the resolution would not be adopted, and a "no" vote was for adoption. The vote was taken and the minority report was accepted, and the resolution was not adopted.

(3) The resolution from Jackson County Medical Society. In essence this resolution paralleled that from Winnebago County. The committee felt that action on the former would satisfy the request from Jackson County. Those who drew up the resolution asked that it lay over for one year. Hutton moved, seconded by G. Henry Mundt, that this portion of the report be approved. Motion carried.

The committee report was signed by R. M. Watrous, J. Eric Gustafson, C. P. Eck, Ray E. Logan and James H. Hutton, chairman. Hutton moved the adoption of the report as a whole, seconded by Fred H. Muller, and carried.

Hutton referred to several resolutions concerning Doctor Paul Hawley, and some recent statements appearing in the press attributed to him. Hutton gave his own impression of the situation and thought it most unfortunate that any member of the medical profession should make disparaging remarks such as were attributed to Hawley. In closing Hutton stated: "I wish that this House of Delegates would do two things:

(1) Express the opinion that a patient should be able to buy in one package the combined medical and surgical care for one illness.

(2) Request its delegates to the American Medical Association to seek to have that section of the Principles of Medical Ethics deleted.

President Sweeney stated that this communication would be referred to the Committee on Miscellaneous Business of which Percy E. Hopkins was the chairman.

The Second Meeting of the House of Delegates adjourned at 5:00 p.m. to meet on Friday morning, May 22, at 8:30 o'clock.

THIRD SESSION OF THE HOUSE OF DELEGATES

May 22, 1953

The third session of the House of Delegates was called to order by President Leo P. A. Sweeney on Friday, May 22, 1953, at 8:45 A. M. The Chairman of the Credentials Committee, Harlan English, reported that 60 delegates and 16 officers and members of the Council had registered for this session. He recommended that the total voting strength should be reported later, as many others would be present later.

Secretary read the minutes of the second session which were approved—motion, Fred H. Muller, second by Warner Newcomb.

The President asked Coye C. Mason to make the announcement of awards for outstanding scientific exhibits. Mason said the secret committee had made the following awards.

ORIGINAL WORK

Gold medal — Booth No. 1

"Persistence of Symptoms Following Cholecystectomy; Etiologic Factors and Preventive Measures". Manuel E. Lichtenstein and Anthony J. Nicosia, Cook County Graduate School of Medicine and Northwestern University Medical School.

Silver Medal — Booth No. 23
"Experimental Diabetes".
Piero P. Foa, Jay A. Smith, Harriett R. Weinstein, Edward G. Nadid, Morton D. Glassman.
Chicago Medical School, Department of Physiology and Pharmacology.

Bronze Medals:

1. Booth No. 17
"Keloids Treated With Hyaluronidase".
Theodore Cornbleet and Hubert Catchpole.
University of Illinois College of Medicine.

2. Booth No. 22
"A Cross Sectional Study of the Subcutaneous Layer of the Anterior and Lateral Trunk" — photographically recorded.
E. D. Congdon
Chicago Medical School Department of Anatomy.

3. Booth No. 18
"Thyroid Tumors".
Leo M. Zimmerman and David H. Wagner
Chicago Medical School and Michael Reese Hospital

EDUCATIONAL VALUE

Gold Medal — Booth No. 6
"Female Sterility"
Frederick H. Falls and Charlotte S. Holt
University of Illinois College of Medicine and Illinois Department of Public Health

Silver Medal — Booth No. 8
"Office Procedures in Proctology"
Manuel G. Spiesman and Louis Malow

Bronze Medals:

1. Booth No. 7
"Myomectomy as Related to Sterility"
Helen L. Button and Edward G. Warnick
Cook County Graduate School of Medicine, Cook County Hospital, Women's and Children's Hospital, Stritch School of Medicine of Loyola University

2. Booth No. 19
"Acute Anuria"
Samuel A. Levinson and Max Berg
University of Illinois College of Medicine

3. Booth No. 25
"Obesity"
P. V. Dilts
Springfield Clinic

Dr. Mason complimented his Committee on Awards, and the exhibitors for the many fine scientific exhibits displayed at this Annual Meeting.

President Sweeney stated that all members are proud of the fine scientific exhibits and likewise are proud of Dr. Mason and his Committee on Scientific Exhibits.

A. F. Goodyear commented on the fine work of Dr. Mason and thought it should be officially recognized by the House of Delegates. He moved, seconded by G. Henry Mundt that a special vote of thanks be given by the House to Dr. Mason and his committee for this fine work. Motion carried unanimously.

The President stated that the next order of business is the election of officers, members of the Council, Delegates and Alternate Delegates to the A.M.A., and members of the Constitutional Committees.

Bornemeier moved that the Secretary of the Chicago Medical Society, who was secretary for their delegates' caucus, be permitted to make all nominations for the C.M.S. delegates; seconded by Fred H. Muller, and carried.

Nominations were in order for the office of president-elect. M. M. Hoeltgen, Chicago, nominated Arkell M. Vaughn of Chicago for the office of President-Elect, second by Fred H. Muller. There being no further nominations, the President declared the nominations closed, and the unanimous vote was for Dr. Vaughn, the Secretary cast the ballot, the President declaring Dr. Vaughn elected. Dr. Vaughn was called to the rostrum and assured the members that he was happy to receive such an honor and gave his assurance that he would assume the responsibility to the extent of his ability. He has spent 23 years in Chicago, although a native of Southern Illinois. He asked for the support of the House of Delegates and all members of the State Society in carrying out the duties entrusted to him.

M. M. Hoeltgen nominated F. M. Nicholson, Chicago, for the office of first Vice-President. There being no further nominations, the President declared the nominations closed. Motion Phifer, second by Knappenberger, that the Secretary cast the affirmative vote for Dr. Nicholson. Motion carried and Secretary cast the ballot for Nicholson.

Arthur F. Goodyear nominated George E. Kirby, Spring Valley, for the office of second Vice-President. As there were no other nominations, the President declared the nominations closed. T. G. Knappenberger moved that the Secretary be instructed to cast the affirmative ballot for Dr. Kirby, second by Goodyear. The vote was unanimous for Dr. Kirby and the Secretary cast the affirmative ballot; the President declared him elected. W. E. Kittler, Rochelle, nominated Harold M. Camp for the office of Secretary-Treasurer. As there were no further nominations, the President declared the nominations closed. Motion, E. E. Davis, second by T. G. Knappenberger, that the President cast the unanimous ballot for Dr. Camp. Motion approved and President declared him elected.

Election of Councilors:

1st District: Joseph S. Lundholm, Rockford, nominated by Norman Sheehe, seconded by E. E. Davis. Dr. Lundholm elected for a three-year term.

2nd District: Lester Reavley, Sterling, nominated Joseph T. O'Neill of Ottawa, second by J. Howard Maloney. Dr. O'Neill elected for three-year term.

3rd District: M. M. Hoeltgen, Chicago, Nominated Edward Piszczek, Chicago, for a three-year term; Dr. Piszczek was elected.

M. M. Hoeltgen nominated F. Lee Stone, Chicago, for a three-year term to succeed himself. Dr. Stone was elected.

M. M. Hoeltgen nominated George A. Hellmuth to

fill the unexpired term of Arkell M. Vaughn, who was elected President-Elect. Hellmuth was elected.

11th District: Donald Meier, St. Anne, nominated Edwin S. Hamilton, Kankakee to succeed himself, for a three-year term. Dr. Hamilton was elected.

Election of Delegates to the A.M.A. It was stated by the President that these delegates elected would take office January 1, 1954 and serve for two years. By proper action, the following were elected for the two-year term.

H. Kenneth Scatliff, Chicago
J. Mather Pfeiffenberger, Alton
Everett P. Coleman, Canton
Fred H. Muller, Chicago
Harlan English, Danville

Election of Alternate Delegates to the A.M.A. — these likewise for a two-year term beginning January 1, 1954. These men by proper action, were elected Alternate Delegates to the A.M.A. for a two-year term.

Eugene T. McEnery, Chicago
Arthur F. Goodyear, Decatur
Edward H. Weld, Rockford
Walter Bornemeier, Chicago
Lester S. Reavley, Sterling

The President stated that the next order of business would be the election of Standing Committees. The following were elected, by proper action.

Medico-Legal Committee: two to be elected for three year term.

Edward Helfers, Chicago
Ralph McReynolds, Quincy

President stated that it would be necessary to elect another member for this committee to fill the unexpired term of Richard H. Greening, until 1954. George Turner, Chicago, was elected to fill this unexpired term of one year.

Medical Education and Hospitals Committee: three members elected for one-year term. By proper action, the following were elected:

George F. O'Brien, Chicago
Karl L. Vehe, Chicago
Harlan English, Danville

Committee on Medical Benevolence: one member elected each year for a three-year term, the term of L. O. Frech, Decatur, ending at this time. By proper action, Dr. Frech was re-elected for a three-year term.

Committee on Medical Testimony: two members elected each year for a four-year term. By proper action, Dr. Harry A. Oberhelman, Chicago and Dr. Edward H. Weld, Rockford, were re-elected for a four-year term.

The President stated that nominations were in order for two members of the Grievance Committee to serve for three years. By proper action, Drs. T. G. Knappenberger, Champaign, and Edward Baker of Lewistown, were elected for the three-year terms.

President Sweeney stated that the next item on the agenda was the fixing of the per capita assessment for 1953.

C. Paul White, Kewanee, moved that the dues remain as they are for 1952; second by Fred H. Muller, Chicago.

F. Lee Stone, Chairman of the Council, stated to the House that the Council recommended that there be no change in annual dues for 1954, that they remain $40.00, of which $20.00 will be sent to the American Medical Education Foundation. The motion was put by the President, and carried; the dues for 1954 will remain $40.00.

English, as Chairman of the Credentials Committee, reported that 96 delegates and 20 officers were present; he moved that this constitute the voting strength for this session. Seconded by T. G. Knappenberger, and carried.

The President stated that the next order of business would be the receiving of Reference Committee reports. He called for Committee "B", Max Hirschfelder, Chairman. Dr. Hirschfelder gave the following report:

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION

The committee gave much thought and study to this report and realized the many problems encountered in the meetings with I.P.A.C. officials. Dr. Coleman and other members of the Committee were present during their Committee hearings. They learned that medical care costs in these programs, had increased materially during the past two years which was a factor in the present deficit in the I.P.A.C. funds. The Committee was commended for the effective manner in which they handled their duties, with the desire to protect the medical profession as much as possible. Efforts were made to keep the costs down, yet endeavor to see that the patients are properly cared for. Resolutions referred to this reference committee from Morgan County and Madison County were carefully reviewed, and the Committee feels that the advisory committee is doing its best in bringing about the changes that are sought in these resolutions. Hirschfelder moves the adoption of this portion of the report, second by E. S. Hamilton, and carried.

Hirschfelder then moves the adoption of the two resolutions regarding fees; second by Fred H. Muller, and carried.

ADVISORY COMMITTEE TO THE UNITED MINE WORKERS HEALTH AND WELFARE FUND

The reference committee commends Dr. Coleman, chairman of the committee, and Dr. Cecil A. Z. Sharp, areal medical director for the United Mine Workers, for their fine cooperation and the smooth handling of problems confronting medical care of miners. It is gratifying to know that no major grievances arose. Hirschfelder moves the adoption of this portion of the report, second by E. E. Davis, and carried.

J. A. Mathis, Pinckneyville, stated that his county, Perry, is dissatisfied with the report of this Medical Advisory Committee. The fee schedule was set up in

1946 and they felt it was their patriotic duty to accept those fees in that year. He stated that Coleman as chairman for the committee has done a fine job, but they fear he is too much inclined to appease these people. His County would like to suggest that when a governmental committee feels that they cannot function, the committee's next duty is to resign.

COMMITTEE ON CONSTITUTION AND BY-LAWS

The Reference Committee reviewed the report of this committee in detail and the proposed changes in the Constitution and By-Laws were thoroughly explained by Dr. Furey, Chairman of the State Society Committee on Constitution and By-Laws. The Reference Committee recommends the adoption of this report, and make the proposed changes which conform to the By-Laws of the A.M.A. Hirschfelder moves the adoption of this portion of the report, second by Harry M. Hedge, and carried.

COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

The Reference Committee appreciated the fine report of the Chairman, and the listing of approved plans. The reference Committee recommends that Blue Cross and Blue Shield promote a greater drive for individual membership, as many individual people are not eligible under the present set up. The approved carriers should also promote more energetic participation in their plans. A resolution from the Jackson County Medical Society is recommended for adoption. Hirschfelder moves the adoption of this portion of the report, second by Robert H. Hayes, Chicago, and carried.

COMMITTEE ON MENTAL HEALTH

This committee has a short report. It is to be commended for its cooperation with the State Department of Public Welfare. The Reference Committee regrets that the report of the committee did not call attention to the very overcrowded and understaffed conditions in our mental hospitals, conditions which were brought out in a resolution, fortified by pictures introduced by the delegate from Peoria Medical Society. The Reference Committee recommends that the Illinois State Medical Society appoint a committee of three or five members to study the status of the mental institutions and to make recommendations to the House of Delegates for definite steps for improvement by the state authorities. Hirschfelder moved the adoption of this portion of the report, second by G. Henry Mundt, and carried.

COMMITTEE ON NECROLOGY

The Reference Committee commends the Committee on Necrology for its report and the supplementary report presented at the first session of the House, and especially for the special remarks concerning prominent members who passed away during the past year. The Committee urges secretaries and all members of component societies to report promptly to the State Secretary's office, the death of members as early as possible. This should likewise be urged by Councilors at the time of their visits to Societies within their respective districts. Hirschfelder moves, second by Fred H. Muller, that this portion of the report be approved, motion carried.

COMMITTEE ON DIABETES

The report of the Diabetes Committee outlines ways to improve the detection and care of diabetic patients. It is recommended that the program committee follow up the suggestion of having one paper on diabetes scheduled each year before their societies. Also worthy of consideration are the other objectives outlined in the report concerning education of communities in regard to the detection and handling of people with diabetes. Hirschfelder moves the adoption of this portion of the report, second by G. Henry Mundt, and carried. The Committee report was signed by Anders J. Weigan, S. M. Goldberger, W. A. Monaghan and Max Hirschfelder, as Chairman. Hirschfelder moves the adoption of the report as a whole, second by C. Paul White, and carried.

President asked Warren W. Furey, Chairman of the Committee on Constitution and By-Laws to present the amendments for action at this time. Dr. Furey stated that the following changes in the Constitution and By-Laws were recommended by the committee:

Article VI; The Council; Section i. By deleting the parenthesis in line 9 around the words (the retiring president) and substituting a comma therefor; "and one councilor-at-large, the retiring president—

Furey moves the adoption of this amendment, second by Fred H. Muller, and carried. Article VI, Section 6. Deletes "in the year 1940 and" and the words "thereafter" from lines 1 and 2. The section will then read: "Each year the Council shall appropriate from the funds of this Society. . . ." That was just a qualifying clause put in when the section was adopted.

Furey moves the adoption of this amendment, second by Harry Mantz, and carried. By-Laws. Chapter V. The House of Delegates. Section 2. Special meetings. . . . by adding the following:

"When a special meeting is thus called, the Secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called".

This is offered to conform with the definition of a special session as contained in the By-Laws of the American Medical Association. Furey moves the adoption of this amendment, second by G. Henry Mundt, and carried.

Amend Chapter V by adding a new Section to be designated as:

Section 4.. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a Certificate signed by the president and/or the secretary of the component society, stating that the

delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified by his county society and so certified to the Secretary of the Illinois State Medical Society.

When a delegate and his alternate are unable to attend a specified meeting, the appropriate authorities of the component society concerned may appoint a substitute delegate and a substitute alternate, who on presenting proper credentials, shall be eligible to regular membership in the House of Delegates.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that meeting. If a delegate, once seated, is unable to be present on account of sickness or for any other emergency, his place may be taken by an alternate, if approved by the Reference Committee on Credentials. After the alternate has been seated, he cannot be replaced. Furey moves the adoption of this new section, seconded by E. S. Hamilton and carried.

Amend by changing Sections 4, 5, 6, 7, and 8 of Chapter V respectively to Sections 5, 6, 7, 8, and 9. Furey moves the adoption of this amendment, second by E. S. Hamilton, and carried.

The President then called for the report of the Reference Committee "C", Warren W. Furey, Chairman.

Furey stated that a number of interested members appeared before the committee at its hearing the previous day and gave much information which the committee greatly appreciated.

COMMITTEE ON CANCER CONTROL:

The annual report of this committee presents a factual story of the hard and determined work of the committee, advisory to the Illinois Division of the American Cancer Society, and of the Bureau of Cancer Control of the State Department of Public Health. The Committee is commended for its fine work. The Reference Committee therefore approves the annual report and commends the Committee for the splendid effort they are making in this important field. Furey moves, second by Fred H. Muller, the adoption of this portion of the report. Motion carried.

COMMITTEE ON TUBERCULOSIS CONTROL

This annual report is a continuing story of the progressive action and excellent work of this fine committee. Special attention is called to the efforts of this committee and of official and voluntary agencies within the state in advancing the program to stamp out tuberculosis. Of special interest is the fact that the Council of the State Society is advocating that every component Society have a Tuberculosis Committee. Fifty-seven component societies had complied at the time this annual report was written. The Reference Committee approves the report, including the recommendations contained within it, and the committee also recommends that this House of Delegates gives commendation to the Committee for its splendid work. Furey moves, second by E. E. Davis, Avon, that this portion of the report be approved. Motion carried.

MEDICAL ADVISORY COMMITTEE TO THE VETERAN'S ADMINISTRATION

This advisory committee reports favorably on the home town care of veterans based upon an agreement between this Society and the Veteran's Administration. There have been no problems of special concern during the past year. The Reference Committee approves the report and desires to commend the Committee for its continuing favorable effort for the health and welfare of both the veterans and members of the medical profession. Furey moves, second by Harlan English, the approval of this portion of the report. Motion carried.

COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

This interesting report presents a problem of serious concern to the profession, the public and governmental agencies. Every member of this Society is urged to read the complete report and study the material contained in it, in the effort to not only familiarize themselves with the recommendations but to also stimulate the interest of the public and local governmental agencies in the seriousness of this problem. Dr. Maxwell, Director of Civil Defense and Dr. Earl H. Blair, Chairman of the Committee, appeared before the committee hearing and contributed much valuable information relative to the report and its implications. They stated that this information contained in the report approved by the Council of the Illinois State Medical Society and of the Chicago Medical Society, had been sent to the Director of Civil Defense and the Civil Defense Committee Chairmen of all County Medical Societies in the areas involved, together with a directive to the Director to give this project priority in their field of activity. They emphasized the need for public education on the seriousness and importance of civil defense, and expressed their appreciation of the endorsement of the program by the medical profession. The Reference Committee recommends approval of the report and also desires to commend the members of this committee for their important and timely contributions to the welfare of the public in the proposed program. Furey moves the adoption of this portion of the report, second by J. Mather Pfeiffenberger, and carried.

COMMITTEE ON BLOOD BANKS

This report is brief and to the point. It contains three recommendations for approval of the House.

1. A plan of operation with civil defense authorities to better utilize blood banking facilities. Dr. Coye C. Mason, chairman of the committee, appeared before the Reference Committee to discuss this report and gave most helpful information. He suggested that in the event of catastrophe, designated authorities in a given area should be made responsible for blood needs, mobilization and distribution. The Reference Committee concurs in the recommendations for approval

by the House. Furey moves that this portion of the report be approved, second by H. D. Junkin, Paris, and carried.

2. Discussion of the value of a series of lectures to County Medical Societies to outline the properties of stored blood and indicate the dangers of blood transfusions. The Reference Committee is in agreement with the need for continuing education in this matter, and recommends the approval of this portion of the report, Furey moves that it be approved, second by Harry M. Hedge, and carried.

3. The desirability of a program sponsored by the Illinois State Medical Society under the jurisdiction of the State Department of Public Health to inspect and license private and hospital laboratories in cross matching as well as in blood grouping the typing. Dr. Mason emphasized the need for such licensing and urged favorable consideration of the recommendations with the understanding that such inspections be done only if the blood bank involved volunteers to be inspected. The Reference Committee approves the recommendations and urges adoption by the House, and commendation of the Committee for its splendid work. Furey moves the approval of this portion of the report, second by T. G. Knappenberger, Champaign, and carried. Furey moved the approval of the Blood Bank Committee as a whole, second by Chas. H. Phifer, Chicago, and carried.

COMMITTEE ON GAMMA GLOBULIN DISTRIBUTION

This report was read by Willis I. Lewis as a member of the committee at the first session of the House, and was referred to this Reference Committee. John L. Reichert, a member of the committee, and Joseph T. O'Neill of the Council attended the hearing and urged wide publicity for the proposed program, both to the profession and to the public. The Reference Committee recognizes the seriousness of this problem and concurs in the recommendations made in this report. Furey moves the adoption of the report with commendation to the committee for its outstanding work, second by T. G. Knappenberger, Champaign, and carried.

Furey stated that four resolutions presented by Pliny R. Blodgett at the opening session of the House all have to do with a democratic effort to preserve our American way of life and to prevent the inroads of creeping socialism in that American way. There was some question as to the propriety of this, a scientific medical organization entering into this activity dealing with governmental problems not directly connected with medicine. The Reference Committee voiced the sentiments of Dr. Blodgett, who appeared at the hearing that these are problems which affect medicine because we in medicine are citizens first and anything that affects the citizens affects all of us as Americans. For this reason, the Reference Committee recommends approval of these resolutions on their merits. The resolutions are:

1. Resolution on I.L.O.

Furey moves the adoption of this resolution, second by J. Mather Pfeiffenberger, Alton. Dr. Blodgett gave an inspiring discussion first stating that our first duty to ourselves is to our country and our citizenship. Our first duty to our God, our profession, is citizenship. He stated that people do not lose their liberty all at once; "we have lost a lot of our liberty in the past 20 years. The forces of socialism are always at work." Blodgett urged the adoption of the resolution. President Sweeney thanked Blodgett for his inspiring discussion. The motion to adopt the resolution was carried.

2. Resolution on the Report of the President's Commission On the Health Needs of the Nation. (introduced at first session of the House). Furey moves the adoption of this resolution, second by G. Henry Mundt, Chicago, and carried.

3. Resolution in support of the proposed 23rd amendment. Furey moves the adoption of this resolution, second by T. G. Knappenberger, Champaign, and carried.

4. Resolution of Social Security.

Furey moves the adoption of this resolution, second by E. S. Hamilton, Kankakee, and carried. Furey stated that his committee is deeply appreciative of the contributions of those who appeared before the committee, and wishes to thank them for their participation.

Furey moves the adoption of the report as a whole, second by Fred H. Muller, Chicago, and carried. The report was signed by Elliott P. Burt, James C. Ellis, and Warren W. Furey, Chairman. The fourth member, Harold W. Miller, although present at the hearing was absent when the report was ready for signatures.

President Sweeney then introduced Mr. James Lowell, representative of the Student American Medical Association. Mr. Lowell stated that he, as well as other students in the Student A.M.A., greatly appreciate the interest of this Society in their organization, and the support that has been given to them by the Illinois State Medical Society. They all look forward to the time when they will become active members of our medical organizations, and many of them are desirous now of getting first-hand information on how the State Medical Societies operate.

The President stated that he had hoped to introduce Dr. Edward J. McCormick, President-Elect of the A.M.A. who was present at the meeting the previous day. Because of storms, the flight he planned to take for his return home had been cancelled, and he was compelled to go home earlier than he had planned, by train.

The President then called for the report of Reference Committee "D", James C. Redington, Chairman. Redington first reported on the annual Report of the COMMITTEE ON RURAL MEDICAL SERVICE.

This Committee's work has been principally confined to two projects:

1. To be of help to the County Health Improvement Association.

2. The continuation of financial aid to students under

the joint Student Loan Fund operated by this Society and the Illinois Agricultural Association. Both of these projects are commendable and the Reference Committee advise the approval of this portion of the report, he so moves, second by E.E. Davis, Avon, and carried.

CRIPPLED CHILDREN'S CLINIC COMMITTEE

This report is a summary of the clinics held throughout Illinois during the past year. Redington moves the approval of this portion of the report, second by Bernard Klein, Joliet, and carried.

COMMITTEE ON INDUSTRIAL HEALTH

The Committee records the reasons we should all be interested in industrial health. Their principal recommendation is that everyone interested or engaged in industrial medicine practice, should endeavor to attend the annual meeting of the Congress on Industrial Health. Redington moves the adoption of this portion of the report, second by E. E. Davis, Avon, and carried.

MATERNAL WELFARE COMMITTEE

This committee has done a very important job very well. The principal thing they are interested in is the reviewing of all puerperal deaths in the entire state. This committee should be highly commended for what they have accomplished, and the Reference Committee recommends the approval of this portion of the report. Redington so moves, second by E. E. Davis, and carried.

ETHICAL RELATIONS COMMITTEE

The Reference Committee was pleased to note that only one case had been referred to this committee during the past year, and they were gratified that such was the case. The Reference Committee recommends the approval of this portion of the report, second by C. H. Hulick, Shelbyville, and carried.

THE COMMITTEE TO INVESTIGATE THE CORONER'S OFFICE

This committee was appointed a year ago by the House of Delegates to attempt to get a medical examiner instead of a county coroner. They reported that this change could not be made without a constitutional amendment, which would be difficult to get. In cooperation with the Illinois Bar Association, a bill was prepared which if passed, would accomplish the same purpose through legislative action. The bill was quite recently introduced. The Reference Committee recommends the approval of this portion of the report, and Redington so moves, second by Harlan English, and carried.

COMMITTEE ON NURSING

This committee has been quite active the past year. The nursing profession is reorganizing their societies, as heretofore there have been several nursing organizations. More recently these have been grouped into two societies, The American Nurses' Association and The League for Nursing. The accreditation of nurses' training schools has caused considerable annoyance and confusion to many hospitals. The Committee on Nursing, and especially its chairman, have attended a number of meetings devoted to this subject, as shown in their reports, which this Reference Committee hopes all members will read carefully. The State Society Committee has worked with, and cooperated with a similar committee from the American Medical Association. The Reference Committee was especially impressed by the fact that more bedside nursing should be given to patients needing the services of members of the nursing profession. The Reference Committee desires to commend the Nursing Committee and its chairman for their fine work and they recommend the approval of this portion of their report. Redington moves adoption of the report, second by E. E. Davis, Avon, and carried. The report was signed by Fred H. Muller, Oscar Hawkinson, W. H. Schowengerdt and James C. Redington, Chairman. Redington moves the adoption of the report of the committee as a whole, second by Fred H. Muller, and carried.

President Sweeney called for the report of the Reference Committee "E". Charles H. Phifer, chairman, presented the following report:

WOMAN'S AUXILIARY

The Reference Committee has carefully reviewed the report of the President of the Woman's Auxiliary to the Illinois State Medical Society and desires to congratulate them on the occasion of their Silver Anniversary being celebrated at this annual meeting. The Committee also commends the many activities of the Auxiliary as shown in their report. American Medicine is under many obligations to the Woman's Auxiliary, and it greatly appreciates the wonderful public relations work the organization has done at the county, state and national levels. In this work, the Woman's Auxiliary in Illinois has played a leading role. The committee regrets that every component county society in the state does not have a Woman's Auxiliary. The committee urges each member of this House to make a constructive effort to see that an active Auxiliary is organized in their respective counties. The Committee commends the publishing of the Auxiliary News, and they recommend to the House that the Council be instructed to provide the necessary funds to carry on this objective, if they remain unable to find a suitable sponsor. Phifer moved the adoption of this portion of the report, second by T. G. Knappenberger, Champaign, and carried.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Reference Committee notes with pleasure the interest and activities of the Advisory Committee to the Woman's Auxiliary, as well as their close association, guidance and counsel in matters pertaining to the Auxiliary. The work done by this committee is most constructive and important to the Auxiliary and to the State Medical Society. This is an important liaison between these two organizations and should be

encouraged and continued. Phifer moved the adoption of this portion of the report, second by Bernard Klein, Joliet, and carried.

COMMITTEE ON CARDIOVASCULAR DISEASE

This report states the reason this committee was created, to "act as a liaison between the Chicago Heart Association and the Illinois Heart Association and the Illinois State Medical Society. To furnish information to this Society concerning the activities of all the organizations both lay and professional, political and scientific, which are concerning themselves regarding cardiovascular diseases." The reference Committee is pleased to see the effort made by the committee to study and correlate the lay and professional groups working in this field of medicine. The Committee recommends this committee's continued and strenuous effort should be directed toward keeping medicine's rightful position of leadership in the future control of cardiovascular diseases. Phifer moves the adoption of this portion of the report, second by T. G. Knappenberger, Champaign, and carried.

EDITORS OF THE ILLINOIS MEDICAL JOURNAL

The Reference Committee is pleased to know that the new Chicago office of the State Society provides more adequate space and better working conditions to help dispose of the large volume of business transacted in this location. The Reference Committee believes the changes in the Journal, contents and format, are for a distinctive improvement. The Committee recommends that the department "Know Your Society" be continued.

The Committee recommends that the Editors and the Journal Committee screen very carefully all advertising material contracted for publication in the Illinois Medical Journal; this especially cogent because in any advertisement appearing in the Journal the recommendation of the medical profession is implied for any product advertised.

The Committee appreciates the difficulties which the Editors and Board have surmounted, and desires to commend them for their untiring efforts. Phifer moves the adoption of this portion of the report, second by Bernard Klein, Joliet, and carried.

REPORT OF THE JOURNAL COMMITTEE AND THE EDITORIAL BOARD

The Reference Committee believes the joint meetings of the Journal Committee and the Editorial Board are most important, and they recommend that they be continued with one objective in mind, namely, that they try to create and maintain the best state medical journal in the United States. The most important item in a medical journal is the scientific papers. Careful thinking should continuously be given to the character, scientific accuracy and educational value to the profession of this state, as well as of the Middle-West regarding all scientific papers appearing in the Journal. We appreciate this in a state journal.

Your Reference Committee is of the opinion that there is no place in the United States where there are greater resources of medical schools, teaching hospitals, medical research institutions, or more renowned faculties, as well as general information of scientific education and research than exist in the State of Illinois and neighboring states. The Illinois Medical Journal commands a circulation of nearly 10,000 physicians in Illinois in addition to a potential circulation in other states. This should be an adequate fulcrum to develop the oustanding state medical journal that our membership desires and the Middle-West needs. The committee commends the Journal Committee and Editorial Board for the work they have done; your past success should inspire you to greater efforts.

Phifer moves the adoption of this portion of the report, second by T. G. Knappenberger, Champaign, and carried.

COMMITTEE ON SCIENTIFIC WORK

The Reference Committee is pleased to notice the increased interest developed by the creation of new sections on Cardiovascular Diseases, Dermatology, Anesthesiology, and Allergy. The interest manifested in each of these has been very enthusiastic. If additional sections are to be considered, they should be carefully evaluated as to their need and demand for such sections. It has been suggested to this Committee that it would simplify the reading of the official program if each day's scientific program would appear as a unit for each day. The Committee desires to commend the Committee on Scientific Work for their excellent work for the annual meeting; including the careful selection of speakers and subjects, distinguished speakers and material. The scientific exhibits remain at their high standard level and they have attracted great interest at this meeting. The Reference Committee recommends that a vote of thanks be given by the House of Delegates to this Committee and its chairman, and Director of Scientific Exhibits, Dr. Coye C. Mason. Phifer moves the adoption of this portion of the report, second by T. G. Knappenberger, Champaign, and carried. The report was signed by H. D. Junkin, Kenneth Schnepp, George Turner, and Charles H. Phifer, as chairman. Phifer moves the adoption of the report as a whole, second by C. H. Hulick, Shelbyville and carried.

President Sweeney called for the next Reference Committee Report. The Committee on Miscellaneous Business, of which Percy E. Hopkins was chairman. Hopkins stated that his Reference Committee had a long hearing on Wednesday, and not being able to complete their report had to sit in session Thursday afternoon missing the second meeting of the House of Delegates. It was the opinion of the Committee that too much work had been assigned to them, although there were no complaints at the time required to complete their work. The resolutions assigned to this Committee were controversial, which meant many members desiring to be heard.

COMMITTEE ON NUTRITION

The Report was carefully examined by the Committee and the members of the Committee on Nutrition are to be commended for their fine work. Due to the illness of Dr. Lee T. Hoyt of Roseville, the Co-chairman, Paul A. Dailey was asked to assume this responsibility. The Committee has done fine work which should be continued.

Hopkins moves the adoption of this portion of the report, second by J. Mather Pfeiffenberger, Alton, and carried.

COMMITTEE ON MEDICAL HISTORY

The Committee approves the report of the Committee on Medical History and takes great pleasure in anticipating the presentation of the next volume before the meeting in 1954. The array of medical and literary talent whose names appear on the medical history committee roster assures both the quality and authenticity of their monumental effort. This Committee realizes that securing of information is but one phase in the production of a medical history, and we feel that the entire membership should be appreciative of the efforts of Dr. Hutton and his entire committee. Particular credit is due to Dr. D. J. Davis who has consented to edit the entire volume. The Reference Committee urges every member of this Society to cooperate in providing the necessary material as it had been informed that but few of the county societies have thus far responded to the request of the Medical History Committee for material. Hopkins moves the adoption of this portion of the report, second by Bernard Klein, Joliet, and carried.

COMMITTEE ON INTERPROFESSIONAL RELATIONS

The Committee report was carefully reviewed by the Reference Committee. The competent and conscientious nature of Dr. Slaughter's Committee is shown in the continuing growth of the Interprofessional Council, comprising most of the professional groups of the state. This is also quite obvious by the able manner in which the duties of the committee are carried out in cooperation with the other groups. The efforts of other state societies to emulate the program of the Illinois Professional Council by forming similar organizations speaks more highly for the successful efforts of this Committee than anything the Reference Committee might add. Hopkins moves the adoption of this portion of the report, second by J. Mather Pfeiffenberger, Alton, and carried.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

The Reference Committee has reviewed the report of the Delegates from this Society to the A.M.A. and wishes to commend the delegates both for the stand they have taken in controversial matters and for the concise manner in which all activities have been reported. In matters of policy, the delegates have closely adhered to those determined desirable by the State Society. We are indebted to Harlan English for his detailed report of the activities of the House of Delegates.

The recommendations of Dr. Louis H. Bauer concurred in by the House of Delegates to the effect that county societies be more rigid in their requirements for membership and in the disciplining of members who transgress would go far to prevent some of the abuses which are causing much concern at this time. The Reference Committee notes with pride the continued appointment of members of the Illinois delegation to important Reference Committees at most sessions of the American Medical Association. The Reference Committee is of the opinion that the Illinois State Medical Society is indebted to Dr. English and Illinois delegates for the completeness of the report and the previous efforts referred to in the report. Dr. Hopkins moves the adoption of this portion of the report, second by Fred H. Muller, Chicago, and carried.

REPORT OF THE COMMITTEE ON MILITARY AFFAIRS

This report likewise was carefully studied by the Reference Committee and it is quite obvious that the great responsibility of this group and the unpopular nature of their work has conspired to make their work more difficult. They have had to meet the opposition effected by its decisions and at the same time fulfilling its patriotic duty in finding enough physicians available to meet the military needs of the nation. We commend the committee both for its individual acceptance of responsibility and for the manner in which the duties have been discharged. Hopkins moves the adoption of this portion of the report, second by Fred H. Muller of Chicago, and carried.

EDUCATIONAL COMMITTEE

On behalf of the Illinois State Medical Society, we wish to express our gratitude for the tremendous amount of work successfully concluded during the past year. Dr. Charles P. Blair and his Co-Chairman, Dr. Karl Vehe, and the other members of the committee have been instumental in the improving of public relations during these past several months. The untiring efforts of the committee to place the medical profession in a favorable light by giving freely of their time to educate in things medical will be productive of good for a long time. The Committee notes with interest the continued expansion of the circulation of HEALTH TALK and feels that this fact confirms its value. The television and radio programs continue to be outstanding as well as popular. Hopkins moves the adoption of this portion of the report, second by Fred H. Muller of Chicago and carried.

Blair stated that having been reviewed by two Reference Committees, his committee feels quite confident.

ACTIONS ON RESOLUTIONS

Hopkins states that the preceding report by this Reference Committee is made after due consideration and deliberation among the members of the Committee plus the advice given by individual members of the House of Delegates.

The Committee spent a considerable amount of time in conducting open hearings to consider resolutions, at which time appeared many members of the State Society who were interested in them. No member who appeared before the Committee was limited to time and was allowed to discuss a resolution as they desired. Several resolutions they received were identical and enabled the Committee to effect combinations. A resolution submitted from the Logan County Medical Society had been erroneously submitted, and was withdrawn. A resolution submitted by Dr. F. E. Bollaert of Rock Island County was also withdrawn by Dr. Bollaert. Dr. Hopkins stated that no action was necessary for this portion of the report.

Resolutions introduced at the first session of the House of Delegates, one from the Chicago Medical Society and the other from the Morgan County Society were identical. These had to do with the Principles of Medical Ethics and the interpretation thereof and were carefully considered by the Committee. The Committee is of the opinion that this is the proper way to dispose of this problem. The Committee recommends the adoption of these resolutions. Unless there are some instructions to the contrary it would seem necessary that one of these resolutions which are similar, be read. President Sweeney stated that this would be agreeable, then Dr. Hopkins read the resolution from the Chicago Medical Society. Hopkins moves that the resolutions be adopted. Second by H. Close Hesseltine of Chicago and carried. Hopkins stated that he will read the resolution from the St. Clair County Society as a model, and in detail it is essentially the same as other resolutions from the Ogle County Society, The Rock Island County Society, McLean County Medical Society, Montgomery County Society, and the DeKalb County Society. These resolutions were to all intents and purposes identical, all recommending adoption or support of the so-called ELABORATION OF THE PRINCIPLES OF MEDICAL ETHICS OF THE IOWA STATE MEDICAL SOCIETY. The Committee considered these resolutions and also received information from proponents of the resolutions, and is of the opinion that it is not within the province of the Illinois State Medical Society to adopt such an elaboration of principles inasmuch as the Constitution and By-Laws of this Society provides that the Principles of Medical Ethics of the A.M.A. are binding upon the members of the component societies. The Committee is of the opinion that a resolution presented and previously adopted from the Chicago Medical Society is the proper manner of disposing of this problem of medical ethics. The Committee, therefore, recommends that these resolutions be not adopted. Hopkins moves that the resolution be not adopted, second by Harry Mantz of Alton and carried.

The resolution submitted by the St. Clair County Medical Society at the first Session of the House having to do with ethics of the medical profession was carefully considered by the Committee, and the Committee recommends the adoption of this resolution. Hopkins moves the adoption of this resolution, second by Fred H. Muller of Chicago. Hopkins states that this resolution is similar to one adopted by the Council of the Chicago Medical Society. It seemed to the Committee that there was a little different matter and not the detail associated with it in regard to a certain individual who will be mentioned by name in the next resolution. This we felt, effected a little different angle which we thought might be recommended to the House for adoption. The motion to adopt the resolution was carried.

A resolution from the Ogle County Medical Society having to do with unfavorable publicity, as well as a resolution from the Vermilion County Medical Society, is similar in substance to a resolution presented by the Chicago Medical Society and are therefore, combined with the resolution from the Chicago Medical Society. The Committee recommends the adoption of these resolutions. Hopkins so moves, second by Frank H. Fowler, Chicago, and Harry Mantz of Alton. Reference was made by several delegates of the discussion the previous day by Dr. James H. Hutton. One motion made, was to the effect that Hutton's statements be approved and given wide publicity. The other motion that the Illinois Delegates to the A.M.A. be instructed as to the wishes and desires of this House of Delegates. President Sweeney declared both motions out of order. Sweeney then asked the Parliamentarian, Warren W. Furey for a clarification. Furey stated that Hutton's remarks were not referred to a Reference Committee the previous day, and should be considered under unfinished business, if it was so desired. To add this to the report of the Reference Committee is out of order.

E. S. Hamilton in discussing the motion said he heard one discussant state that Dr. Hawley was not a member of the A.M.A. Hamilton corrected that statement showing that he is a Service Member of the A.M.A., and under the Constitution and By-Laws of the A.M.A. "Service Members shall retain membership as long as they are on active duty and thereafter after they have been retired in accordance with Federal Law and do not engage in active practice". There was considerable discussion on the wording of the resolution in regard to "general practitioner", and "a member of the American Medical Association". A motion was made to amend this resolution by taking out the words "and not" so that it would read "a general practitioner and a member of the American Medical Association". G. Henry Mundt of Chicago, moved that the two words "general practitioner" be

eliminated, amendment seconded. Further discussion by William Walton, Belleville; E. S. Hamilton, Kankakee; The Secretary; Joseph S. Lundholm, Rockford; W. E. Kittler, Rochelle; Frank Fowler, Chicago and others. Walter Bornemeier, Chicago suggested the deletion of the entire reference of Dr. Hawley being a general practitioner or any membership in the A.M.A. Frank Fowler moved that the words "service member" be inserted to help clarify the statement.

Furey stated that the discussion is getting out of line, because we have too many amendments. He believes it would be better to have one at a time. President Sweeney requested that they will first vote on the second amendment to delete the words "general practitioner". The vote was taken and the amendment carried. Sweeney said discussion on the first amendment was now in order. Hopkins read the first part of the resolution. "Whereas Dr. Paul R. Hawley, the Director of the American College of Surgeons, who lists his address as 40 East Erie Street, Chicago, Illinois, a general practitioner and not a member of the American Medical Association" — We have taken out the words "a general practitioner". The first amendment refers to the words "and not." It has been shown that Dr. Hawley is designated by the American Medical Association as a "Service Member". Dr. Mundt made a substitute motion that the Committee be empowered to inquire — as to the membership status of Dr. Hawley. Second by W. E. Kittler, Rochelle.

President Sweeney stated that we are voting on whether or not you want to consider the substitute motion. Motion was carried. Now we will vote on the substitute motion which would give the Committee the power to change the wording. Motion was carried. President Sweeney said we will now vote on the resolution as amended. Hopkins stated the resolution will read; "Whereas Dr. Paul R. Hawley, the Director of the American College of Surgeons, who lists his address as 40 East Erie Street, Chicago, Illinois, a member of the American Medical Association" — The vote was taken and the resolution as amended was carried.

Hopkins desired to thank the members of his committee, G. F. Cummins, Wright Adams, E. A. Piszczek, and J. A. Mathis. He then moved the adoption of the report as a whole, as amended. Motion seconded by C. H. Hulick, Shelbyville, and carried. Wm. Walton, Belleville, moved that a rising vote of thanks to Dr. Hopkins and his Committee for the excellent work they have done. Second by many and carried, all standing and applauding.

The President then called upon Dr. Hutton to elaborate on his statements at the Second session of the House of Delegates. Hutton stated that remarks made by members of the Medical profession voicing such statements as have recently been publicized in the press it places the entire profession in a bad light with the public. He hopes his words may stimulate an official express from this House.

G. Henry Mundt, Chicago, discussed the proposal, saying he is heartily in accord with Hutton's statements. There is motion before the House that Hutton's letter be approved. Mundt hoped someone would move that the Illinois Delegates to the A.M.A. from this Society be instructed to endeavor to get that portion of the Principles of Medical Ethics pertaining to the splitting of fees, deleted.

President Sweeney states that there is a motion before the House and on account of its wording, he would like to have an expression from Mr. Neal, as the Legal Counsel for the Society. Neal expressed his opinion on the matter in some detail. Harlan English stated that this Society will have ten official delegates at the A.M.A. meeting in New York, and they will follow any instructions given to them by this House of Delegates. In the discussion of Dr. Mundt's recommendation, I want to assure you that the delegates from Illinois will do what the conclusions say, "Express the opinion that a patient should be able to buy in one package the combined medical and surgical care of one illness, and to seek to have that section of the Code of Ethics deleted".

English further stated that "if Dr. Hutton wants us to take the letter, he may wish to modify it, that is a matter of personal privilege, and for that reason I would like to substitute for all this discussion, a substitute motion that this House of Delegates agrees with these two conclusions; (1) Express the opinion that a patient should be able to buy in one package the combined medical and surgical care of one illness; and (2) request us to go to the A.M.A. and seek to have that section of the Code of Ethics relating to fee splitting deleted. Motion seconded by Wm. H. Walton, Belleville.

The question was called for, by the President, for the substitute motion; the substitute motion was carried. Dr. Walton then moved that the House of Delegates approve the views of Dr. English; motion second. It was stated by Dr. Furey that the motion of Dr. English was an amendment. This was carried, then the motion as amended was carried.

E. H. Weld, Rockford, asked for permission to introduce two motions, permission granted.

(1) That the delegates to the A.M.A. from Illinois be instructed to exert every effort to have all states adopt the Illinois plan. Seconded by O. W. Rest and others. Motion carried.

(2) That the delegates to the A.M.A. be instructed to present a suitable resolution to the House of Delegates to the American Medical Association urging all states to adopt the plan pioneered by the Illinois State Medical Society for contributing to the American Medical Education Foundation. Second by O. W. Rest, Chicago and carried.

C. Paul White of Kewanee, asked for an explanation of the Hutton letter; if there is anything wrong about it, the House should know because they will talk about it when they get home. White moves, that the statements in Hutton's letter be accepted as an expression of this House in answer to the unfavorable criticism

by Dr. Paul R. Hawley. Motion seconded by Caesar Portes, Chicago. Walter Bornemeier, Chicago said he enjoyed the remarks as made at the previous Session of the House and most of us believe in the ultimate conclusions. However, he is opposed to the motion.

Hutton stated that he was pleased with the action taken when the motion of Dr. English and approval of his two recommendations was made. "In adopting that motion, you accomplished what I desired; at this time it would be an anticlimax to adopt Dr. White's motion, and I feel that he should withdraw it." White stated that he had accomplished exactly what he desired, so with the approval of his second, he would withdraw the motion. Dr. Portes, who seconded the motion likewise withdrew.

Leo P. A. Sweeney, President, thanked the members for their fine spirit of cooperation. He appreciates everything that has been done for him during his term of office as President of this Society. He stated that he is thankful to every member of this fine Society, he has met many of them during the past two years in all parts of the state, and he has made many friends during that period.

INDUCTION OF THE PRESIDENT-ELECT

He stated that "it is now my pleasant duty to induct into office, the new President of the Illinois State Medical Society". He asked H. A. Felts of Marion, to escort Dr. and Mrs. Willis I. Lewis, of Herrin, to the rostrum. "It is now my extreme pleasure and happy duty to pin on to your new President, the badge which states that he is the President of the Illinois State Medical Society, Dr. and Mrs. Lewis, I thank you for the many things you have done for me this past year, and I wish you both a happy year. I now give you, Dr. Lewis, this official gavel and greet you as the President of the Illinois State Medical Society, — Ladies and Gentlemen, your President, Willis I. Lewis of Herrin."

President Lewis: "Thank you President Leo. I want to thank you for all you have done for me during the past year. I wish to thank you for the gavel and trust that I shall wield it as gently and efficiently as you have at this meeting. I again want to thank all the official family, the Councilors, and all the employees of the office for their many helpful aids to me during the past year in preparing me. I have tried hard to prepare myself for this year to come. I trust that I have learned a little and I certainly expect to learn much more. I realize that there are many arduous duties connected with the office of president. I shall try to the best of my ability to do them. I appreciate this great honor, and I thank you for giving it to me. The Illinois State Medical Society is the fourth largest, being exceeded in members only by New York, Pennsylvania and California. It is not only one of the largest, but in my opinion, the best. I really believe that we do have the best state medical society in the United States. We have a wonderful background, a wonderful past, and I trust that I shall do something during the coming year to help maintain this wonderful record for the future. It has been a great relief to me that the resolution for continuation of the $20.00 assessment for the American Medical Education Foundation was adopted. I have seen first hand in England the terrible condition of the medical profession since medicine became socialized there. They are not free agents; they become pawns of a socialistic government. I trust that we in America will never get in such straits. If all other states wish to go that way, let us in Illinois stay in the regular channels. I have no particular outlined policy for the coming year but I trust we will all have good fellowship throughout the state. I do not enjoy bickering. I assure you will full cooperation of all the members of this Society, we will go forward."

E. S. Hamilton, Kankakee said he would like at this time to evidence the appreciation of this House of Delegates on the manner in which the immediate Past President has presided at the meetings. He has maintained order and good fellowship in a most trying time. He asks for a rising vote of thanks to Leo P. A. Sweeney, our retiring President. All rise while applauding.

The Secretary: I would like to get an expression from this House concerning the arrangement this year in having the extra session of the House, three instead of two sessions as formerly was the custom. We did this largely on our own, and we would like to know if it meets with your approval, and you recommend that it be continued. The plan approved with applause.

The Secretary said he would like to receive permission from the House to send their official thanks to all those who have been responsible for the success of this meeting. Motion: J. Mather Pfeiffenberger, Alton, that permission be granted. Second by Percy E. Hopkins, Chicago, motion carried.

The Secretary referred to the new Committee on Necrology. "We get death notices from a number of sources, from the Journal of the A.M.A., newspaper clippings, reports from County Societies, and from individual members. Unfortunately, some deaths of members are not reported, and we receive notice through the post office when releases are not delivered, and this may be a year or more after the member died. In the report of the Committee on Necrology, there was one name about which we were in doubt, as to whether the member is dead or alive. I hope that all members of this House in addition to component Society officers, will notify our office promptly when a member dies."

President Lewis stated that if there is no further business, a motion for adjournment is in order. E. S. Hamilton moves that we adjourn sine die. Motion seconded by J. Mather Pfeiffenberger and carried.

The House adjourned sine die at 12:25 P.M.

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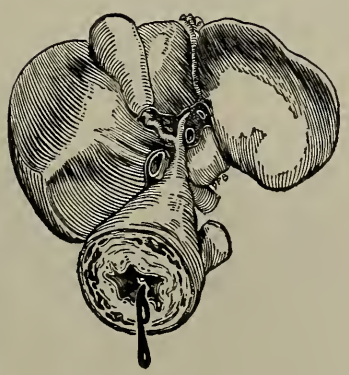
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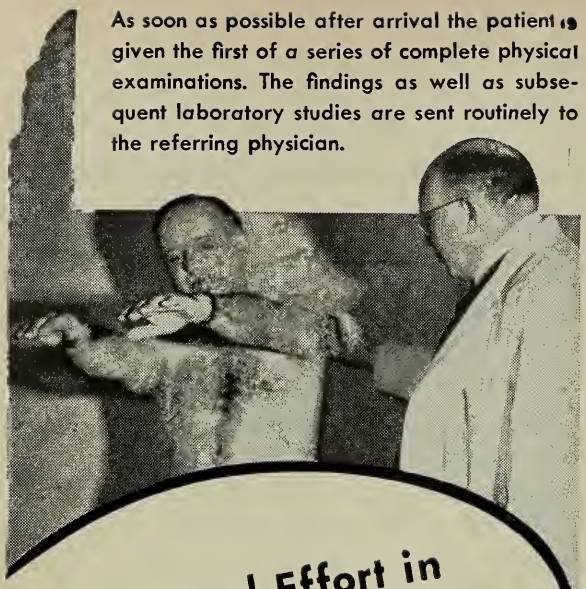
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SURGERY IN JAUNDICED PATIENTS

An analysis of 100 consecutive jaundiced patients showed that the correct preoperative diagnosis of obstructive (surgical or extrahepatic) jaundice had been made in 89 patients. A benign cause was found in approximately one out of two, a malignant cause in one out of three, and a nonsurgical (medical) cause in approximately one out of ten cases. Since the latter group was not correctly differentiated from surgical jaundice, an unnecessary exploratory resulted. The obstructive jaundice in the 89 patients correctly diagnosed before surgery was limited to a relatively few cases. In 44 of the cases one or more stones was removed from the common duct, and in four patients a stone was not recovered but was presumed to have passed recently into the duodenum. It is regrettable that a postoperative stricture of the common duct was found in seven patients who had previously undergone gall bladder surgery elsewhere. Despite the many articles calling attention to the potential dangers of gall bladder surgery, all too many strictures result. Twenty-one cases of carcinoma involving the head of the pancreas or the papilla of Vater comprised the majority of the malignant group of 34 cases but surprisingly enough, carcinoma of the bile ducts was responsible in 10 of the cases. In three patients, metastatic malignancy from the gastrointestinal tract produced extrahepatic obstruction. Therefore, for practical purposes, the indications for surgery in jaundiced patients can be narrowed down to the patient's having a diagnosis of common duct stone, postoperative stricture, or carcinomatous obstruction of the extrahepatic ducts. *Robert M. Zollinger, M.D., and Richard G. Saleeby, M.D., Indications For Surgery In Jaundiced Patients. J. Indiana M.A. June 1953.*

Only by the discovery and treatment of the early case can the ultimate conquest of tuberculosis be effected. Mass X-ray surveys have contributed immeasurably toward this end. At the same time the number of new-found cases, coupled with the decided decrease in the disease mortality rate, has created an increased need for additional beds. That need has now reached alarming proportions and constitutes a major problem in tuberculosis control. J. Winthrop Peabody, M.D., J.A.M.A., December 13, 1952.





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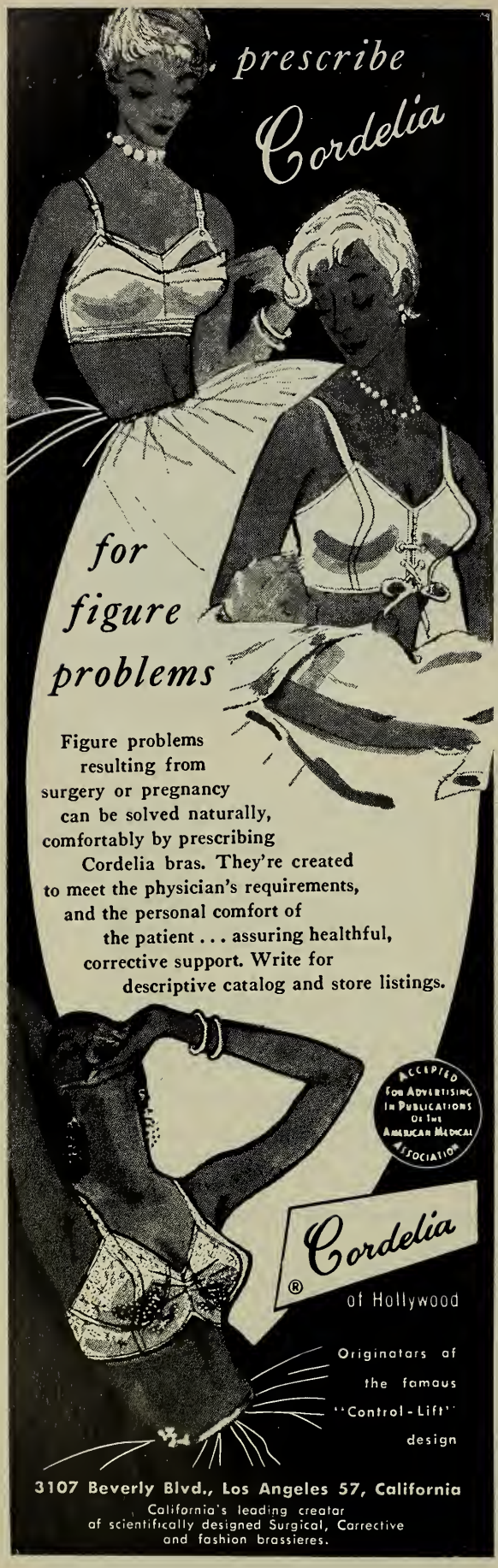
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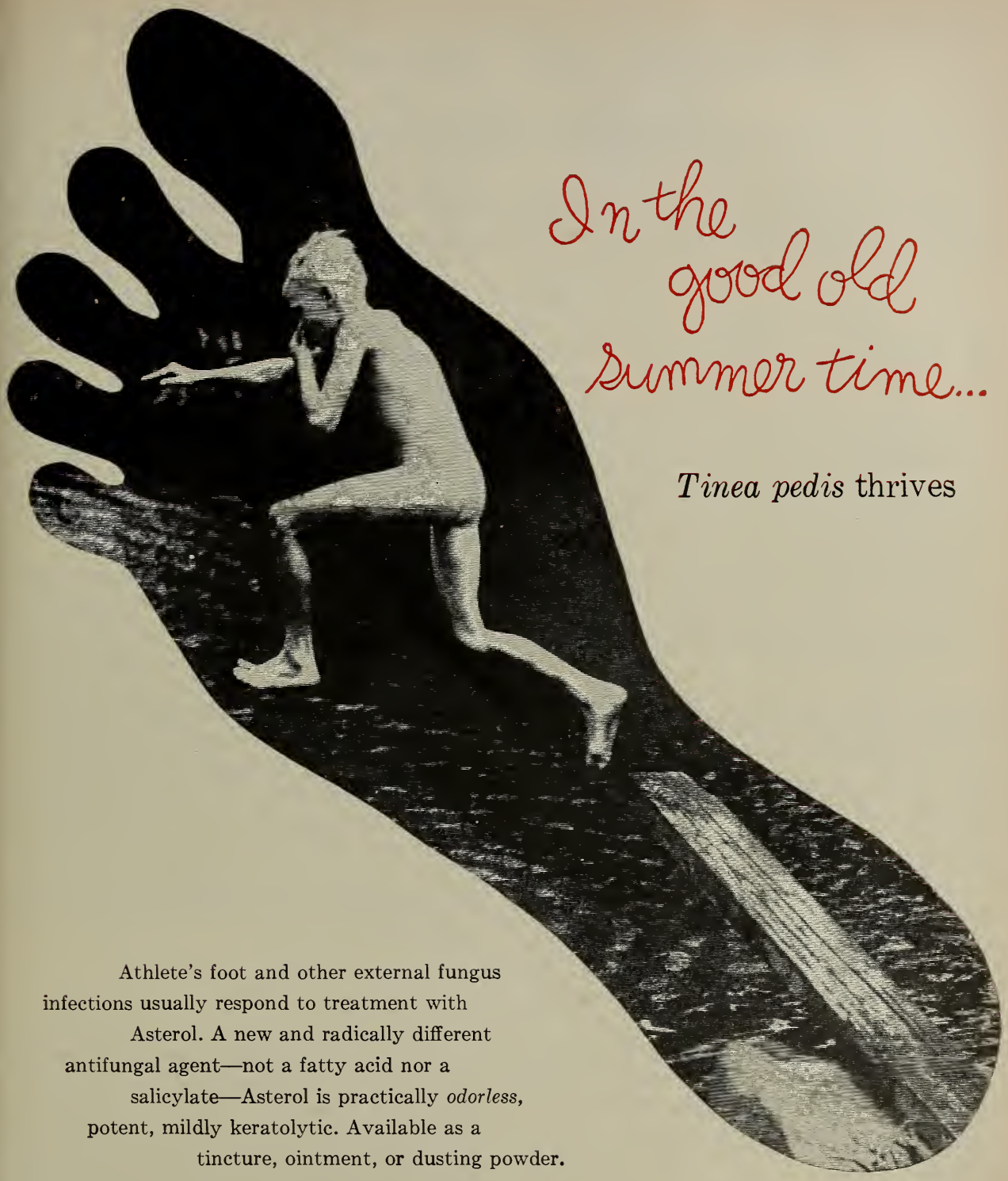
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THE EFFECT OF ISONIAZID IN TUBERCULOSIS

Clinical observations have confirmed the early laboratory findings and have shown that isoniazid has an important place in the therapy of tuberculosis. Robitzek, Selikoff, and Ornstein noted rapid clinical improvement in a group of patients with extensive active pulmonary tuberculosis, treated over a period of four to seven months, followed by roentgenographic clearing in about 60 per cent of their patients, and sputum conversion in 25 per cent of the total group. Clark, Muschenheim, McDermott, et al. treated a small group of patients with miliary tuberculosis with isoniazid alone and obtained rapid defervescence and clearing on roentgenograms as fast as could be expected from therapy with streptomycin. Less striking results were noted in the treatment of tuberculous meningitis, although clinical or laboratory evidence of improvement was noted in seven of 10 patients treated with isoniazid. The Medical Research Council of England attempted to compare the effect of isoniazid on pulmonary tuberculosis with that of streptomycin and PAS, on the basis of observation of a large group of patients. After a period of three months they concluded that isoniazid alone was as effective as streptomycin and PAS in producing defervescence and clearing of pulmonary lesions but gain in weight was more rapid and greater in patients receiving isoniazid. The drug is easily absorbed and well tolerated by the patient. One single dose of 3 mg. per Kg. of body weight produces a maximum plasma concentration of 1.3 to 3.4 micrograms per cc. within one to six hours, and this slowly tapers off within the next six to 24 hours. It diffuses easily into the body fluids. Therapeutically effective levels were obtained in the spinal fluid and in the pleural exudate. The bulk of the drug, 50 to 70 per cent, is excreted with the urine. *Joseph Zeichner, M.D., and William G. Childress, M.D., Observations On The Effect Of Isoniazid In Acute And Chronic Tuberculous Pulmonary Lesions. New York. J.M., June 1, 1953.*

With progressive improvement in treatment, fewer tuberculosis patients are dying of the disease. Therefore, for isolation treatment in hospitals, for aftercare, and for rehabilitation, we will probably continue to require more, not fewer, beds for some time to come. Division of Hospital Facilities, Public Health Reports, July, 1952.



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Questions and Answers About Health Care Plans

What is the relationship between the various Blue Cross and Blue Shield Plans in Illinois?

The two Blue Cross Plans and the four Blue Shield Plans are all separate corporations with separate Boards of Trustees. However, each Blue Shield Plan is affiliated with a Blue Cross Plan which handles enrollment and most administrative procedures. A joint Executive Director and executive staff is the general rule. Illinois Medical Service (Blue Shield) is affiliated with the Chicago Blue Cross Plan; the Rockford and Alton Blue Shield Plans are co-ordinated with the Rockford Blue Cross Plan; and the Rock Island County Blue Shield Plan is co-ordinated with the Iowa Blue Cross Plan.

Why are there so many different Blue Cross and Blue Shield Plans?

Because Blue Cross and Blue Shield are essentially community projects, each Blue Shield Plan in Illinois having been sponsored originally by a county medical society and each Blue Cross Plan by a group of civic-minded individuals representing hospitals, the medical profession, employers, labor, etc. — in fact, the community at large. Differences in viewpoint as to benefits and rates are a factor. With growth and experience, and realization of mutuality of purpose, consolidation and merger of some Plans has taken place in the past and may well occur in the future. Some states, like Illinois, have multiple Blue Cross and Blue Shield Plans; in other states there is only one state-wide Blue Cross Plan and one Blue Shield Plan.

How many Blue Shield Plans are there in Illinois?

There are four — the quoted enrollment figures as of June 30, 1952, being: (1) Illinois Medical Service, headquarters Chicago, 722,138 members (affiliated with the Chicago Blue Cross Plan); (2) Medical-Surgical Service of Illinois, headquarters Alton, 12,750 members (co-ordinated with the Rockford Blue Cross Plan); (3) Northern Illinois Medical Service Corporation, headquarters Rockford, 36,639 members (co-ordinated with the Rockford Blue Cross Plan); and (4) Rock Island County Medical Service, headquarters Moline, 19,773 members (co-ordinated with the Iowa Blue Cross Plan).

Which Blue Shield Plans and commercial insurance companies are approved by the Illinois State Medical Society?

The Illinois State Medical Society has approved the four nonprofit Blue Shield Plans operating in the state and sponsored by various medical societies. Total membership in the four Blue Shield Plans as of June 30, 1952, was 791,300.

It has directly sponsored the "Illinois Plan" for Prepaid Medical and Surgical Insurance by certain approved commercial insurance companies offering Society-approved policies. These carriers are: G. H. Poulsen and Company (Metropolitan Casualty Insurance Company), the Aetna Casualty and Surety Company, North American Accident Insurance Company, Illinois Mutual Casualty Company, Northern Trust Life Insurance Company, and the John Hancock Mutual Life Insurance Company. As of December 31, 1952, it is estimated that approximately 402,835 people were covered by these companies.

Tuberculosis is a completely unnecessary disease. It is a communicable disease caused by a specific micro-organism. Money spent on its control under the guidance of competent administrators is more than returned to the general economy through eliminating loss of production by those so protected and through converting tax dollar consumers into tax paying citizens. Although every person must die eventually of something, tuberculosis definitely is not included in that group of inevitable fatalities. Desirable though it is to spend money on research and control programs for heart disease and other non-communicable public health problems, it is poor economy to do so at the expense of tuberculosis control programs. Tuberculosis control, therefore, should continue to receive individual support from appropriating bodies, public health administrators, and the general public. James E. Perkins, M.D., Bulletin of the NTA, April, 1953.

Clinical Evaluation of Phenergan® in Hay Fever

In the management of hay fever, physicians know that it is not always possible or practical to carry out desensitization therapy. Until definitive measures can be instituted, the administration of an appropriate antihistaminic agent offers the most effective method for alleviating allergic symptoms.

Most efficacious . . . longest-acting antihistamine[5]

Since long-term therapy is involved in the management of hay fever, numerous investigators have studied Phenergan because of its marked duration of action and high potency.[1-5] Waldbott and Young[2] were among the first in the United States to report the successful use of Phenergan in hay fever and allergic rhinitis. In a recent study of 102 patients with hay fever, Silbert[3] stated: ". . . results obtained with Phenergan in symptomatic relief of pollen hay fever were far superior to those obtained with any other antihistaminic agent." The mild sedation produced by Phenergan was distinctly beneficial in many patients.

Individualized dosage for therapy without side effects

Silbert's findings suggest that before deciding that symptoms cannot be controlled without producing side effects, the physician should try various doses of Phenergan to determine the *individualized* dosage that controls symptoms without causing drowsiness.

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A significant observation of Peshkin[5] is that therapeutic doses of Phenergan (1 or 2 tablets daily) do not inhibit or even diminish the size of the cutaneous diagnostic sensitization reactions commonly observed in allergy practice. On the basis of his studies with children as well as adults, Peshkin concludes that Phenergan is ". . . a valuable and safe drug to administer to allergic patients of all ages."[5]

Phenergan is supplied as Tablets containing 12.5 mg. Phenergan; and as a peach-flavored Syrup containing 6.25 mg. Phenergan in each teaspoonful (5 cc).

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1. *Bain, W.A., and others: Lancet 2:47 (July 9) 1949*
2. *Waldbott, G.L., and Young, M.I.: J. Allergy 19:313 (Sept.) 1948*
3. *Silbert, N.E.: Ann. Allergy 10:328-334 (May-June) 1952*
4. *Halpern, B.N.: J. Allergy 18:263 (July) 1947*
5. *Peshkin, M.M., and others: Ann. Allergy 9:727 (Nov.-Dec.) 1951*

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H. J. Carr, M.D., Staff Physician.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will glady furnish same promptly.

THE SURGERY OF INFANCY AND CHILDHOOD — Its Principles and Techniques: By Robert E. Gross, M.D., D.Sc., William E. Ladd, Professor of Children's Surgery, The Harvard Medical School, Chief of Surgical Service, The Children's Hospital, Boston. With 1488 illustrations on 567 figures. Drawings by Etta Piotti. 1000 pages. Philadelphia and London: W. B. Saunders Company, 1953. $16.00.

ESSENTIAL UROLOGY. By Fletcher H. Colby, M.D., Chief of the Urological Service, Massachusetts General Hospital; Associate Clinical Professor of Genito-Urinary Surgery, Harvard Medical School, Boston, Massachusetts; Urological Consultant, Lakeville State Sanatorium, Middleboro, Massachusetts. Second Edition. The Williams and Wilkins Company, Baltimore, 1953. $8.00.

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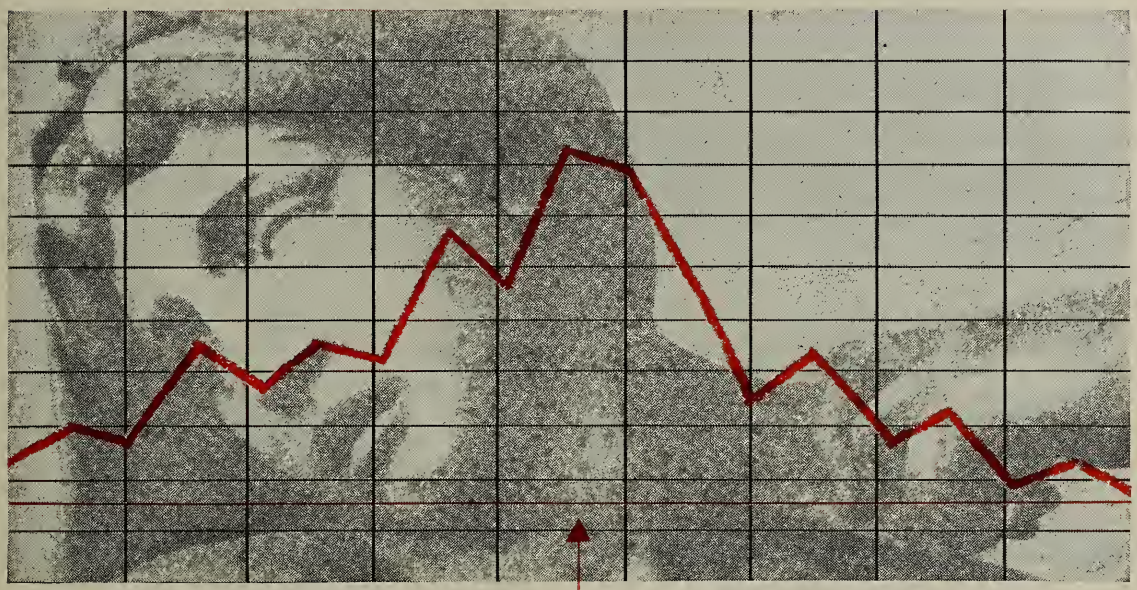
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EFFECTIVE INHALATION THERAPY: By Edwin Rayner Levine, M.D., Chairman of the Committee on Physiologic Therapy, American College of Chest Physicians, Formerly Director of the Chest Service, Michael Reese Hospital, Chicago. With the cooperation of: Alvan L. Barach, M.D., J. Winthrop Peabody, M.D., and Maurice S. Segal, M.D. National Cylinder Gas Company, Medical Division, Chicago 11. $4.50.

BALLISTOCARDIOGRAPHY: The Application of the Direct Ballistocardiograph to Clinical Medicine. By William Dock, B.S., M.D., F.A.C.P., Harry Mandelbaum, M.D., F.A.C.P., and Robert Mandelbaum, B.A., M.D. With 153 illustrations. The C. V. Mosby Company, 1953. $9.50.

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Fool's Haven. By C. C. Cawley, author of "No Trip Like This and Other Stories". House of Edinboro, Publishers, Boston, Massachusetts. $2.75.

Twenty-Five Years of Sex Research History of the National Research Council Committee for Research in Problems of Sex, 1922-1947: By Sophie D. Aberle, Member of the National Science Board of the National Science Foundation; and George W. Corner, Carnegie Institute of Washington. 248 pages. Philadelphia and London: W. B. Saunders Company, 1953. $4.00.

Proceedings of the Forty-Sixth Annual Meeting (Including 1952 Spring Meeting held in The Homestead, Hot Springs, Va.) of Life Insurance Association of America, held in The Waldorf-Astoria, New York, N. Y., December 9 and 10, 1952.

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Visual Anatomy. Thorax and Abdomen. By Sydney



M. Friedman, M.D., Ph.D., Professor of Anatomy, University of British Columbia, Vancouver, Canada. Formerly, Associate Professor of Anatomy, McGill University, Montreal, Canada. Charles C. Thomas, Publisher, Springfield, Illinois. $10.50.

CLINICAL OBSTETRICS. By Members of the Staff of the Pennsylvania Hospital. Edited by Clifford B. Lull, M.D., Late Director Division of Obstetrics and Gynecology, Pennsylvania Hospital and Robert A. Kimbrough, M.D., Director of the Division of Obstetrics and Gynecology, Pennsylvania Hospital, Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania, Gynecologist to the Graduate Hospital. 392 illustrations and 8 color plates. J. B. Lippincott Company, Philadelphia. $10.00.

The cost of preventable diseases imposes a staggering burden upon the human race. Every step that can be taken toward lessening this burden will not only diminish suffering and prolong human life; it will also increase productivity and promote prosperity. C. E. A. Winslow, The Cost of Sickness and the Price of Health, WHO Monograph Series No. 7, 1951.

The concept that the patient himself must heal his tuberculosis remains basic. John H. Skavlem, M.D., The W. Va. Med. J., Dec., 1952.

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A normal person can be aggressive as the need arises, submissive when the interests of the group are served best, and withdrawn when meditation is desired. The ability to vary emotional response is based on self-confidence. Self-confidence arises out of an essentially loving attitude of a parent for a child. The person who has a minimum of anxiety, i.e., self concern, felt in childhood that his parents were essentially pleased with him. Because of the ego-strength arising out of this relationship, such an adult will be able to use the three modes of social adjustment and meet reality demands. The neurotic person is able to use only one of these mechanisms and must suppress the other two. If his parents were hypercritical or demanding, he reacted with submission to please them and gain the security of their approval. If they were withdrawn and introverted he became aggressive in order to gain the comfort of even angry attention. If the environment of childhood is too exacting or hostile, a child may withdraw into the pleasurable activity of thumbsucking, masturbation, or phantasy. These reaction patterns usually continue into adult life. The introverted husbands are very likely the end result of the last example of childhood trauma described above. They are devoid of self-confidence and live on the edge of life as a spectator. They are unable to expand into life interests because of an unconscious fear of environmental threat. Never having experienced sufficient acceptance, they feel essentially unworthy, inferior. Ever fearful of meeting with hostility, rebuff, or disapproval they dare not venture from the safety and isolation of their ivory tower of withdrawal. *Sylvan A. Steiner, M.D., Marital Conflict And Functional Illness. M. Ann. District of Columbia, Sept. 1952.*

Only a small percentage of the general hospitals take a chest X-ray on any appreciable number of hospital admissions, yet one per cent to three per cent of all hospital admissions have unrecognized tuberculosis. Paul S. Phelps, M.D., and Reginald C. Edson, M.D., Conn. State Med. J., May, 1952.

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1. Heimer, C. B., Grayzel, H. G. and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.



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bursting, sharp, throbbing, and even lancinating. The headache that develops as a result of uncorrected refractive errors of hyperopic and astigmatic type usually recedes after the eyes have been rested. The headache rarely if ever develops during the night but may be present in the morning after a prolonged period of reading the night before. This often accounts for the so-called Monday morning headache which occurs after an unusual amount of reading over a week-end. *W. H. Morrison, M.D., Headache From The Standpoint Of The Ophthalmologist. Nebraska M. J. May, 1953.*

Health education of the public is often considered the responsibility of organized voluntary and official community agencies. Of course, it is also the physician's personal responsibility. He certainly should educate his patients and their families and do what he can as part of the community program. Health education methods have changed materially in recent years, with much greater emphasis on community organization and on helping the people to help themselves. Hugh R. Leavell, M.D., The New England J. of Med., December 4, 1952.

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Mankind is paying the penalty for assuming the upright posture. In his evolutionary climb from four-footed to bipedal locomotion, the supporting structures of the body have not kept pace with this change. There are other exhibitions of anatomic lack of adaptation to the upright position, notably in the inguinal canal regions. There, the muscular pattern and sphincter mechanisms are unable to meet the demands made up them. There is little doubt that the tensile strength of fascia varies with the individual. Extreme degrees of weakness are, in the author's opinion, responsible for the very advanced cases of varicose veins. In clinical practice, patients with marked fascial weakness will develop recurrent varicosities quickly, following any form of therapy. This factor deserves strong consideration and apparently has gone unnoticed

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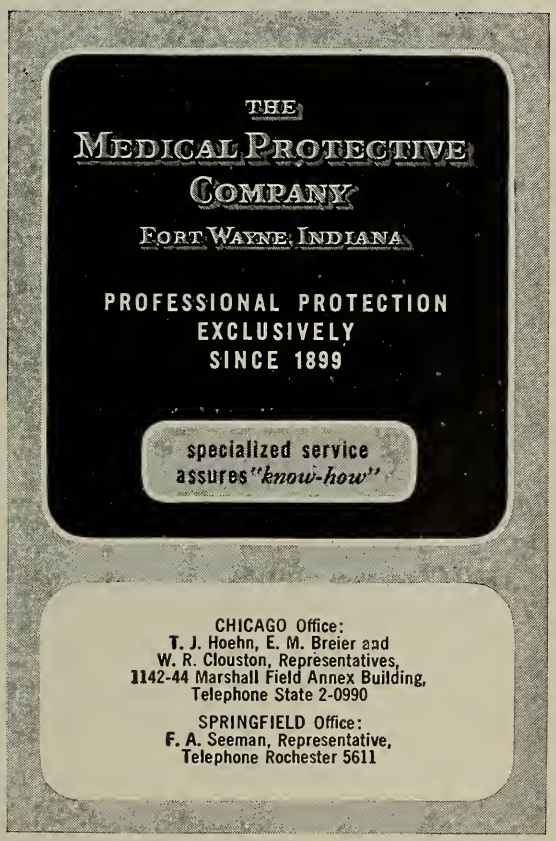
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up to the present time. It should be obvious that an inherited weakness of this kind never can be eliminated by any mode of therapy and indeed experience bears this out. *H. I. Biegeleisen, M.D. Varicose Veins, A Chronic Disease. New York J. Med. Apr. 15, 1953.*

Rehabilitation is not a part of treatment but is the entire process by which we take the tuberculous patient as he is, guide him into the sanatorium, treat his physical disease and his fears, guide him into the proper social and economic channels, and finally place him securely and permanently in his community in all safety to himself and others. Joseph A. Smith, M.D., Public Health News, Sept., 1952.

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The relationship of elderly men of indeterminate economic status to a high tuberculosis death rate has long been established. Mary Dempsey, The American Review of Tuberculosis, July, 1952.

OBESITY

There are a few tricks, gleaned from experience, that may be worth noting. For some unknown reason, better results are achieved if the total caloric intake is divided into three even partitions, rather than having the patient eat a tiny breakfast and lunch in order to have a big dinner at night. It is remarkable how many obese persons follow the unbalanced intake method instinctively, and experimental evidence from rats indicates that food eaten all at a sitting tends to greater weight than if the same total quantity is consumed at three or four sittings. One must watch out for alcohol. Many persons forget that the caloric value of alcohol is 7 calories per cc. so that 3 ounces of whisky yields 315 calories. The "drink or two" before dinner not only adds dietary fuel but usually also enhances appetite and removes inhibitions. "Appetite killers" such as benzedrine or dexedrine, have been advocated as adjuvants to dietary regimens. They also are used for the emotional lift in relieving depression and to boost morale for dietary maintenance. It has not been our practice to use these drugs (and no collaborating psychiatrist so far has recommended them for any of our patients). In reality they are crutches to lean upon and it usually is wiser to face and work out the long-term problem squarely. It is unwise to yield to the plea, "Doctor, can't I diet six days a week and take a holiday on the seventh?" much like the Lenten Sunday. Experience has taught that this system is far harder on the patient, and Sunday's overeating plays havoc with the adjusted metabolism as well as the emotional pattern of the dieter. *John Eager Howard, M.D., Obesity. Maryland Med. J. April, 1953.*

One of the values of a community-wide mass survey is the disclosure of localities or groups in which there is a high prevalence rate where screening efforts may be concentrated. Arthur C. Christie, M.D., J.A.M.A., January 10, 1953.

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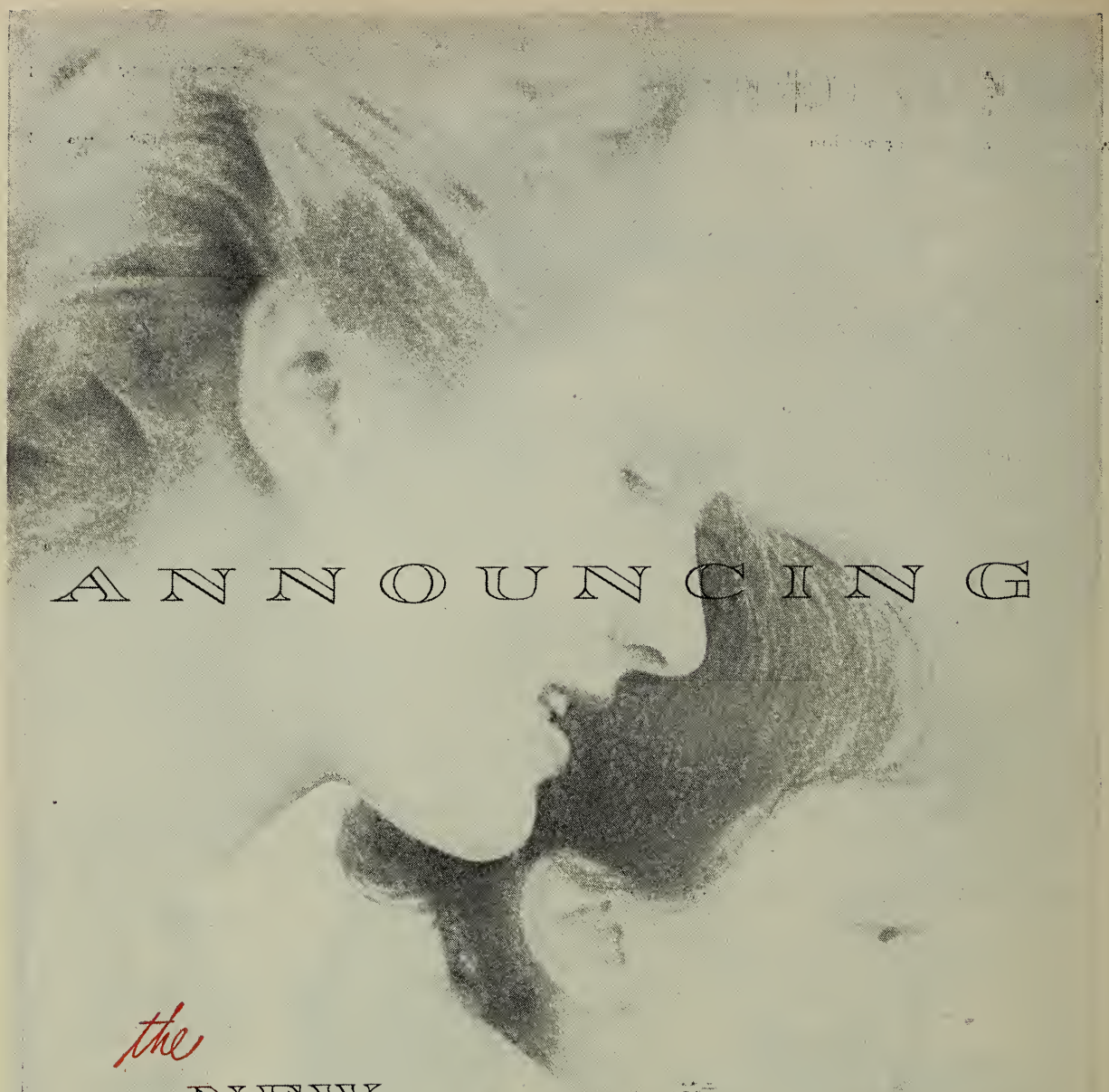
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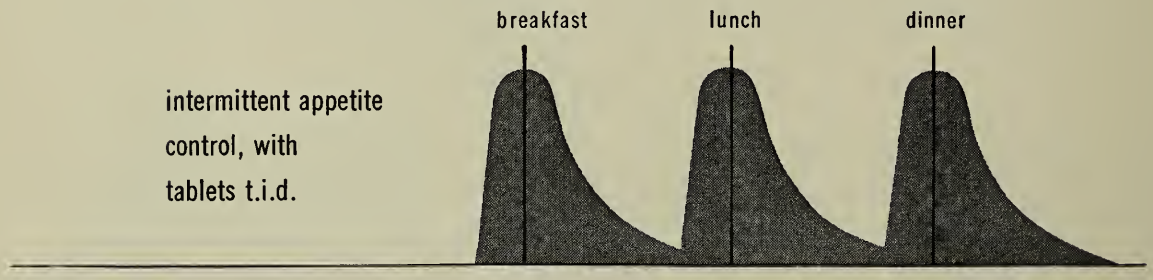


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Vol. 104, No. 3 September, 1953

Tracheotomy in Chest Injuries

Hans Von Leden, M.D.
Chicago

The operation known to us as tracheotomy provides some of the brightest links in the chain of medical evolution. Tracheotomies were performed successfully many years before the birth of Christ, and the dramatic results have sparked the imaginations of physicians and laymen alike throughout the centuries. The basic principle of bypassing an upper respiratory obstruction and the essentials of the surgical technique have varied but little, and even the conventional silver cannula has shown only minor changes during the past four hundred years.

Considerable surprise, therefore, greeted the adaptation of this operation to entirely different indications, when Galloway[6] reported its use in bulbar poliomyelitis ten years ago. Since then, extensive clinical and experimental evidence has proved the value of tracheotomy in bulbar poliomyelitis and other conditions complicated by the accumulation of secretions in the lower respiratory passages.[3,5,7,8,12,13,14,15]

A recent discussion of these newer indications for tracheotomy by this speaker[16] before the American Academy of Ophthalmology and Otolaryngology includes a detailed account of the physiologic principles involved. and stresses the advantage of tracheotomic aspirations in preventing pulmonary complications and asphyxia. Secretory obstruction of the lower respiratory passages may occur in a variety of diseases affecting every subdivision of medicine. Table 1 details a number of conditions in which the speaker and his associates employed a tracheotomy because the patient was unable to expel tracheo-bronchial secretions over an extended period of time. To these indications Collins[2] has recently added eclampsia with secretory obstruction, in which "tracheotomy can mean the difference between survival or death."

TABLE 1
TRACHEOTOMY IN SECRETORY OBSTRUCTION
ETIOLOGY OF OBSTRUCTION

A.	Medical disorders
	1) Contagious diseases
	Bulbar poliomyelitis
	Tetanus
	Spinal poliomyelitis
	Epidemic encephalitis
	2) Neurologic conditions
	Disseminated encephalo-myelitis
	Cerebro-vascular accidents
	3) Muscular weakness
	Myasthenia gravis
	Convalescent poliomyelitis
	4) Poisonings
	Botulism
	Barbiturate poisonings
	Morphine poisonings
	5) Coma or severe debility
	Uremia, etc.
B	Surgical disorders
	1) Post-operative complications
	2) Post-anesthetic complications

This observation applies equally well to the

From the Departments of Otolaryngology, Northwestern University Medical School, the Cook County Hospital, and Saint Francis Hospital, Evanston, Illinois.

management of many severe accidental injuries.[1,4,17] Industrial progress, as evidenced by the more destructive weapons of war and the ever more powerful machines of peace, continues to increase the ratio of serious bodily injuries. Post-mortem examinations show that the victims of many fatal injuries succumb to pulmonary complications rather than to the force or extent of the injury.

It is, therefore, important to realize that a timely tracheotomy with frequent aspirations of tracheo-bronchial secretions can often prevent death from asphyxia after serious automobile or industrial accidents, and following the injuries of modern warfare. Table 2 presents a list of injuries in which the speaker and his associates have employed a tracheotomy in order to combat an existing secretory obstruction and to prevent pulmonary complications.

TABLE 2
TRACHEOTOMY IN SECRETORY OBSTRUCTION

ETIOLOGY OF OBSTRUCTION
C. Injuries
1) Cranial injuries
Injuries of cervical spine
2) Blast burns
3) Chest injuries

The pathologic physiology of secretory obstruction following traumatic or operative brain injuries has been described in detail by Echols and his associates.[4] The speaker fully endorses their indications for tracheotomy in these entities, and is pleased to report similar good results. — The necessity for tracheotomic aspirations in blast burn injuries is based upon the accumulation of tracheo-bronchial secretions, following the destruction of the ciliary layer of the respiratory tract by the thermic blast.

The speaker has been particularly impressed by his experiences in the treatment of crushing chest injuries, since many of these cases appear "tailor-made" for a tracheotomy. While the pathologic physiology of secretory obstruction in all diseases or injuries rests on dysfunction of the cough reflex, injuries of the chest, by their very nature and location, are apt to interfere with the normal self-cleansing mechanism of the respiratory tract (Table 3). Function of the cough mechanism depends on integrity of the reflex arc, stability of the chest cage, and motion of the muscles of respiration, all of which may be damaged by a crushing chest injury. Coma and general debility, or voluntary suppression of the cough impulse because of pain further impede the normal evacuation of secretions form the trachea and bronchi.

TABLE 3
TRACHEOTOMY IN CHEST INJURIES

Causes of secretory obstruction:
1) Impairment of cough reflex by destruction of reflex arc
abnormal mobility of thorax paralysis of respiratory muscles
2) Coma or general debility
3) Severe pain, with suppression of cough impulse

The danger of hemorrhage into the respiratory passages also complicates the picture of secretory obstruction in injuries of the chest (Table 4). Hemorrhagic obstruction may precede the accumulation of tracheo-bronchial secretions and the aspiration of nasopharyngeal secretions, saliva, and vomitus, which are characteristic of secretory obstruction. On the other hand, leakage of blood into the respiratory tract may be intermittent or prolonged, resulting in the formation of long, tenacious clots, which are difficult to expel.

TABLE 4
TRACHEOTOMY IN CHEST INJURIES

Nature of lower respiratory obstruction:
1) Hemorrhagic obstruction
Blood and clots
2) Secretory obstruction
Tracheo-bronchial secretions
Aspirated saliva
Aspirated naso-pharyngeal secretions
Aspirated vomitus

Irrespective of etiology or composition, the effects of lower respiratory obstruction are always the same, whether the precipitating factor be bulbar poliomyelitis, tetanus, barbiturate poisoning, or a crushing injury of the chest. Locally, the accumulation of secretions, blood, or clots leads to a gradual obstruction of the airway with edema, spasm of the bronchioles, and scattered areas of atelectasis and bronchopneumonia (Table 5). In the presence of pro-

fuse bleeding or coma with resultant aspirations, the patient may literally drown in his own secretion.

TABLE 5
RESULTS OF SECRETORY OBSTRUCTION

I. Local effects:
1. Obstruction of airway
2. Pulmonary edema
3. Spasm of bronchioles
4. Atelectasis
5. Broncho-pneumonia
6. Death by drowning

In addition to these local effects, Gray[9, 10] has described progressive chemical changes in the blood leading to death by asphyxia (Table 6). Any obstruction of the airway and reduction in alveolar ventilation impairs the passage of oxygen into the bloodstream aand the excretion of carbon dioxide from the lungs. The far-reaching

TABLE 6
RESULTS OF SECRETORY OBSTRUCTION

II. Systemic effects:
Chemical changes ——————→ Asphyxia
a) Anoxia
b) Hypercapnia
c) Acidosis

systemic results of anoxia have been experienced by every surgeon. Recent clinical and experimental evidence tends to show that the effects of carbon dioxide accumulation or hypercapnia, are even more disastrous.[11] These observations prove beyond doubt that the administration of carbon dioxide in partial respiratory obstruction is not only pointless, but actually dangerous.

The triad of chemical changes in asphyxia is completed by an acidemia of respiratory and metabolic origin, which aggravates the destructive influence of the other chemical forces. Figure 1 presents a schematic illustration of these changes: it indicates the decrease in arterial oxygen saturation, the increase in free carbonic acid, and the shift of the pH to the acid level during a period of hypoventilation.

This brief description of the salient physiologic changes in lower respiratory obstruction calls for timely and decisive interference, to restore an adequate airway and to remove the accumulating secretions. It is the opinion of the speaker that a tracheotomy is the treatment

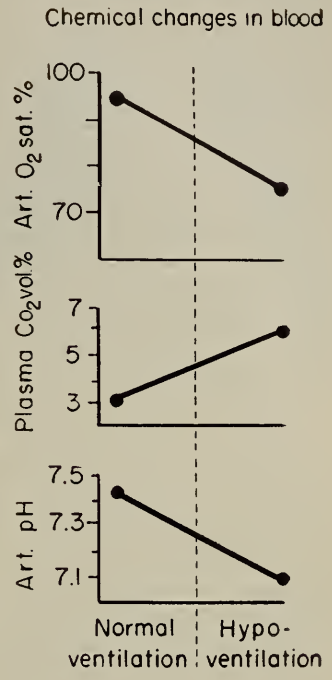


Figure 1. — Changes in blood chemistry during asphyxia. Scheme illustrates decrease in arterial oxygen saturation, increase in carbonic acid, and shift of pH to the acid level during hypoventilation.

of choice in all crushing injuries of the chest with symptoms of severe or prolonged hemorrhagic and secretory obstruction. In these cases, tracheotomy is the only form of therapy that meets all the existing requirements: it bypasses any upper respiratory obstruction, permits easy and continued aspiration of the lower respiratory passages by untrained personnel, facilitates the removal of crusts or clots, relieves the exhaustion of the patient, and eliminates the necessity of performing repeated bronchoscopic aspirations.

While each case of asphyxia presents an individual problem, and should be treated accordingly, certain clincial manifestations call for the performance of a tracheotomy in cases of chest injuries (Table 7): respiratory distress, as

TABLE 7
TRACHEOTOMY IN CHEST INJURIES

Clinical indications:
1) Respiratory distress
 cyanosis
 moist rales
 stridor
2) Inability to cough effectively
3) Hemorrhage into trachea or bronchi
4) Prolonged coma with aspiration
 of salivary and pharyngeal secretions

shown by recurring attacks of cyanosis, moist rales, and larygeal stridor; inability to cough effectively, hemorrhage into the respiratory passages, or prolonged coma with aspiration of pharyngeal and salivary secretions. In doubtful cases the speaker performs an initial bronchoscopic aspiration; if this results in temporary relief, a tracheotomy is clearly indicated.

The following two case histories illustrate our experience with tracheotomy in crushing chest injuries and demonstrate its twofold purpose, for the aspiration of blood and clots in the early stages and for the maintenance of a patent airway during convalescence:

Case 1: M.D., a ten year old girl, was admitted to the hospital on December 15, 1949, with a crushing chest injury after an automobile accident. On admission her general condition was described as poor; she was unconscious and restless, her pulse rate was 160, the respiratory rate 40, and the skin was pale and clammy. The examination further disclosed a concave depression of the anterior chest wall, paradoxical movements of the chest during the respiratory cycle, and moist rales throughout both lung fields. There were also multiple abrasions of scalp, face, and chest, and the mouth was filled with thick, bloody mucus. Roentgenograms showed extensive consolidating changes throughout both lung fields; due to the constant motion of the patient, it was impossible to define the fracture lines of the sternum and ribs roentgenologically.

In spite of oxygen therapy and blood transfusions, the patient became steadily worse; her stupor deepened, and the breath sounds disappeared entirely over the left side of her chest. Five hours after admission she had developed cyanosis and marked respiratory embarrassment. A direct laryngoscopic examination revealed hematoma in the hypopharynx and copious amounts of bloody secretion in the trachea.

A traction screw inserted into the sternum by our thoracic surgeon (Dr. T. Hudson) elevated the depressed fragment of the anterior chest wall and restored normal contour and respiratory excursions of the chest: yet, respiratory difficulties continued. Following tracheotomy, large amounts of blood and secretion were aspirated from the trachea and both bronchi, with immediate improvement in respiration.

During the next two days tracheotomic aspirations were continued at frequent intervals, resulting in a gradual return of pulse rate and respiration to normal levels. On the third postoperative day an unforeseen complication occurred: the traction pin tore out of the sternum and had to be replaced by wire loops around the sterno-costal cartilages (Dr. J. J. Fahey). One day later the temperature rose to 102 degrees, pulse and respirations increased to 156 and 44 respectively, and the patient became extremely restless. The sudden development of cyanosis necessitated an immediate bronchoscopic examination and the removal of several large, tenacious clots.

After this episode the patient recovered rapidly: her further course in the hospital was uneventful, and the tracheotomy cannula was removed on the ninth postoperative day. Figure 2 illustrates the roentgenographic changes at various stages of the illness.

Case 2: H.H., a seventy-three year old man, was admitted to the hospital on March 5, 1950, after he had been injured by a hit-and-run driver. On admission, his general condition was described as poor; he was in shock, and the heartbeat was weak and fibrillating. The physical examination also disclosed a large laceration of the scalp, simple fractures of the right clavicle and humerus with marked displacement, and comminuted fractures of the right tibia and fibula. Following emergency care and blood transfusions (Dr. J. J. Fahey), the patient improved rapidly: the fibrillations ceased, and the blood pressure returned to normal.

Twenty-four hours later the patient developed subcutaneous emphysema over the right chest, and Roentgen studies indicated multiple rib fractures on the right

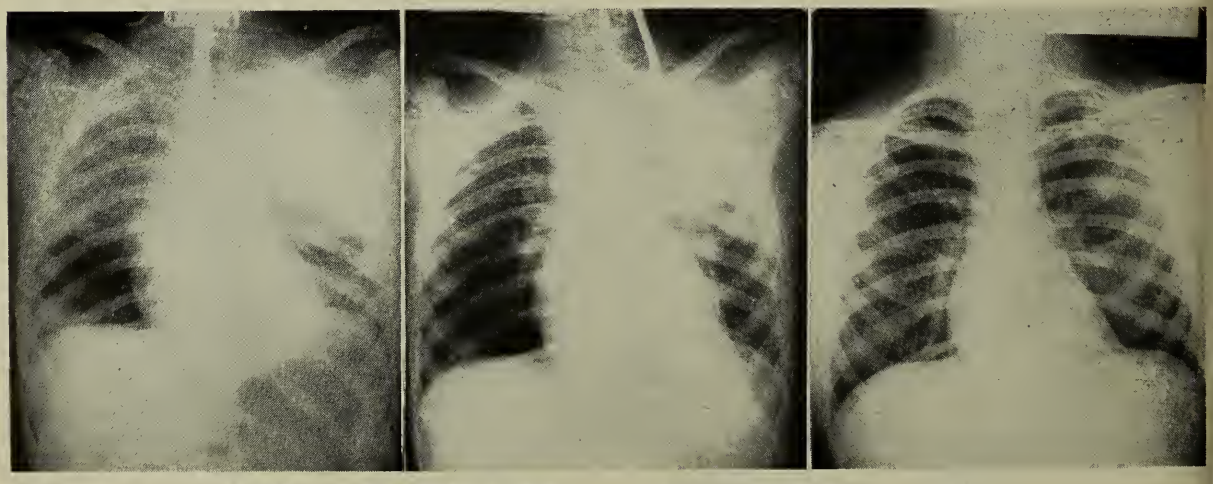


Figure 2. — Roentgenographic changes in case 1: roentgenograms obtained on a) 12-6-49, b) 12-20-49 and c) 1-16-50.

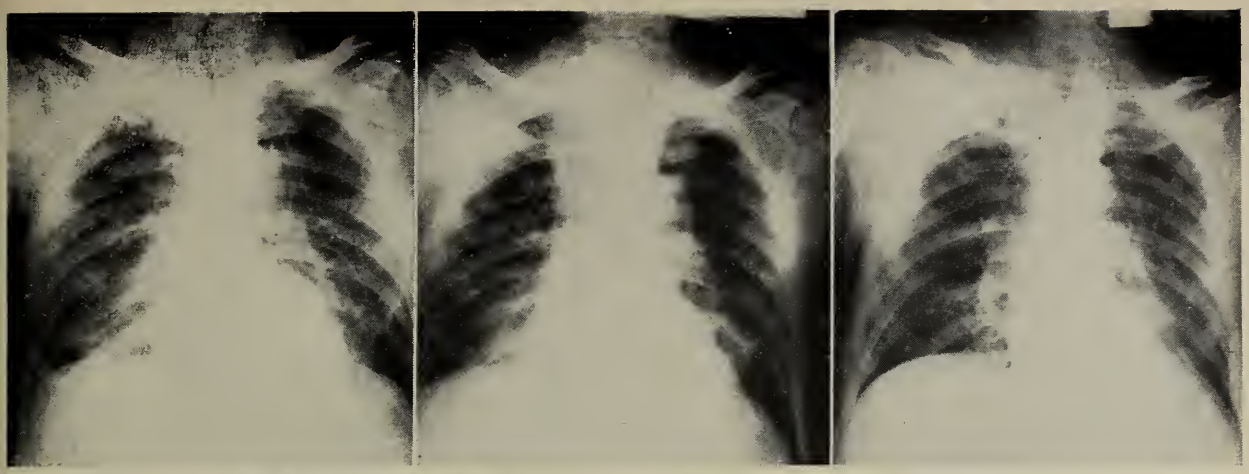


Figure 3. — Roentgenographic changes in case 2: roentgenograms obtained on a) 3-7-50, b) 3-21-50 and c) 4-16-50.

side, with mediastinal emphysema. On the second day after admission the emphysema involved both sides of the neck and chest, and progressive respiratory embarrassment was noted. The temperature had risen from normal to 104.4 degrees, the pulse rate to 146, and the respirations to 40. Our thoracic surgeon (Dr. T. Hudson) advised the performance of a tracheotomy. Bronchial aspirations through the tracheotomy cannula resulted in the removal of much thick, purulent secretion, and in the amelioration of the respiratory difficulties. Within two days temperature, pulse, and respirations returned to normal levels, and the emphysema of neck and chest subsided. Temporary elevations of temperature, pulse, and respiration on the third and fourth post-operative days resulted from the accumulation of crusts in the respiratory tract, and disappeared promptly after adequate tracheo-bronchial toilet.

Removal of the tracheotomy cannula on the eleventh postoperative day led to the development of renewed respiratory embarrassment, which in turn subsided promptly when the cannula was reinserted and tracheobronchial aspirations were resumed. Further recovery was uneventful as far as respiratory function is concerned, and the cannula was removed on the eighteenth postoperative day without difficulties. Successive roentgenograms of the chest (Figure 3) demonstrate the progressive improvement in the condition of this patient following tracheotomy.

COMMENTS

1. In serious chest injuries, a tracheotomy is often a lifesaving procedure.

2. Good results can be expected only if a patent airway is restored in time; surgical intervention cannot be expected to change the prognosis when the patient is in extremis or after asphyxia or cardiac exhaustion have passed beyond the stage of possible recovery.

3. A correctly performed tracheotomy is a harmless procedure and carries no additional risk for patient with respiratory obstruction.

4. Adequate postoperative care is essential for the maintenance of a patent airway. Tracheobronchial secretions must be aspirated at frequent intervals, and the formation of blood clots or crusts may call for a thorough tracheobronchial toilet or bronchoscopic aspiration.

5. Team work is essential in the treatment of crushing chest injuries. Respiratory obstruction with pulmonary complications and asphyxia can usually be avoided if a laryngologist, familiar with the anatomy and physiology of the respiratory tract, is permitted to supervise the problem of airway maintenance.

30 North Michigan Ave.

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DISCUSSION

Dr. Theodore Hudson, Chicago: I come before you as a thoracic surgeon to discuss this matter from that point of view. Dr. Von Leden's excellent paper has dealt with a very important subject and one which will increase in importance as greater and greater numbers of bigger and bigger fools operate more and more automobiles with higher and higher horsepower. The slaughter on our highways is a national disgrace and is a tribute to the stupidity of drivers in general.

There are, so far as I can find, no statistics giving the anatomic causes of death in highway fatalities. It seems reasonable to believe, however, that nearly all deaths will be due to head or chest injuries or a combination of the two.

I cannot speak for cases with cranial damage, but with regard to patients having serious chest injuries as a result of automobile accidents I feel sure that in general the treatment has left much to be desired. My feeling is that if a patient having a chest injury due to automobile accident is brought into the hospital alive he should be saved. Exceptions will be those with head injuries and those in deep shock gasping the last breath of air as they are admitted. General principles that should be followed in the treatment of chest injuries are:—

Maintain Clear Airway

(a) Cough
(b) Tracheal catheterization
(c) Tracheotomy

There should be no doubt in the mind of anyone here that there is absolutely no substitute for good effective coughing in clearing the secretions from the tracheobronchial tree. There is no other way to get secretions from the parenchymal portions of the lungs. Many people with chest injuries can be induced to cough effectively with stabilization of the chest wall and reduction of chest wall pain.

In those who cannot be made to cough, transglottic catheterization by way of the nose should be tried. Many cases can be kept clear in this way.

If these conservative measures fail and there is evidence of retained tracheobronchial secretions, tracheotomy should be done without hesitation. This is especially true in patients with head as well as chest injuries who are in coma and likely to remain so for some time. If there is any difficulty in making a decision for or against tracheotomy, the tracheotomy should be done. The operation is harmless, and may be life-saving.

I believe it is important to remember that tracheobronchial toilet by way of a tracheotomy tube will not remove retained secretions from the parenchyma of the lungs. This can only be done by cough. It is, therefore, urgent that all patients be taught to cough as soon as feasible and possible.

I think it is also important not to leave the tube in too long; once the chest wall is stabilized, the pathologic physiology has been corrected and the patient found able to cough effectively, the tube should be removed.

Prevention and Treatment of Rheumatic Fever

H. William Elghammer, M.D.
Chicago

The extensive research and clinical studies conducted during the past forty years to discover a specific organism causing rheumatic fever have all been unsuccessful. To date the etiological factor of this disease remains unknown.

Clinical evidence strongly suggests a definite relationship between hemolytic streptococcal infections and the development of the rheumatic fever process. Similarly hemolytic streptococcal infections occuring in rheumatic fever patients during the latent or inactive phase of the disease is followed in approximately 50 per cent by activation of the disease process.

The pathogenesis of the disease is far from clear. However, clinical experience, bacteriological and immunological studies have yielded a variety of facts, which suggest the pathological nature of rheumatic fever.

The marked familial tendency, the high incidence of onset in the younger child before puberty and the failure of specific measures to prevent the disease leads one to doubt that rheumatic fever is an infectious process and rather indicates that the disease may be metabolic in nature. We find that the collagenous tissue conditioned by various intrinsic factors i.e. heredity, nutritional state, endocrine imbalance, responds to certain environmental changes producing the clinical and pathological picture we have come to recognize as rheumatic fever. Among the environmental changes one finds most constantly streptococcal infections and it is conceivable that the response on the part of the host to the streptococcal invasion may act as a trigger mechanism initiating the pathological changes indentified with rheumatic fever.

The prevention of the initial attack as well as the recurrent attacks in rheumatic fever subjects is of greatest importance. The success of a preventative program depends on a clear understanding of the natural history of the disease. The constitutional factors must be considered and effort made to bring about an optimal state of health, together with the prevention and limitation of hemolytic streptococcal infections. By these means the resistance of the host is increased and the precipitating factor eliminated or greatly diminished.

The close relationship between scarlet fever and rheumatic fever is well established and similarly upper respiratory infections in children often precipitate rheumatic fever. The epidemic form of upper respiratory infections are in high degree caused by hemolytic streptococci and the carrier rate of similar organism in young children is very high.

Vigorous anti-streptococcal therapy should therefore be instituted whenever such infections are encountered. Isolation of patients so infected is very desirable, but often difficult. The most effective treatment is the judicious employment of penicillin. The administration of penicillin should be continued into the convalescent period in order to prevent reinfection. In carriers penicillin has been found very effective in eradicating streptococci from the oropharynx.

The prevention of initiating streptococcal infection may be successfully accomplished by the prolonged use of sulfadiazine.

This method of prophylaxis, however, is limited to groups of the population, particularly to individuals, who have had one or more attacks of rheumatic fever. The recurrency rate is high following an attack of rheumatic fever and decreases as time elapses. It is advisable to protect all patients who are convalescing from a recent attack of rheumatic fever by the continuous daily administration of sulfadiazine for a period of at least two years. The dosage commonly employed is .5 gm. twice daily. These patients should be under close supervision, with repeated blood counts during the first two months of the regime, in order to detect any untoward effect.

From the Department of Pediatrics, Stritch School of Medicine, Loyola University, Mercy Hospital, La Rabida Jackson Park Sanitarium, Chicago, Illinois.

Presented before the Section on Preventive Medicine and Public Health, 112th Annual Meeting, Illinois State Medical Society, Chicago, May 13-15, 1952.

In reviewing the treatment of rheumatic fever, during the past twenty five years, one finds a uniform empirical treatment based upon predisposing causes and symptoms of the disease.

This basic treatment has been, from time to time, supplemented by the introduction of a variety of supposed specific therapeutic measures reflecting current changes in etiological concepts.

Among these specific measures we may recall the removal of tonsils, the attempt to produce immunity by convalescent sera and vaccines, desensitization by the injection of streptococcal products and of late the use of chemotherapy and antibiotics. None of these measures has proven to be of therapeutic value and some have been observed to be actually harmful, increasing the severity of the disease.

The treatment of rheumatic fever consists of measures to support, strengthen and improve the host, bringing about normal metabolic function, resistance and arrest of the disease. I wish to emphasize the value of the empirical basic treatment employed for many years past and to restate and evaluate the various procedures employed.

The most outstanding symptoms of the disease are fatigue, exhaustion and anxiety. Real rest and relaxation, both physically and emotionally, may be established through a sympathetic and encouraging attitude of the attending physician. *Emotional and mental rest, and alleviation of anxiety appears to be of greater therapeutic importance than physical rest.* The mere insistance of bed rest, enforced under a cloud of apprehension of some approaching damage to the child's heart, can hardly be expected to produce a favorable result. The patient as well as the parents and all attending personnel should be made thoroughly familiar with the problems at hand and the task to be accomplished.

Faulty nutrition should receive careful attention through adequate high protein diet and optimal vitamin intake. The role of vitamin C is of particular interest and should be further studied and evaluated.

Anemia should be actively treated by the administration of iron and transfusions of blood, preferably sedimented blood cells having less volume and lower salt content than whole blood, more frequently employed.

The isolation of the patient is of major therapeutic value. *Hereby we are able to reduce exogenous stress and strain by the establishment of an environment commensurate with his ability and strength to carry on his daily physical, mental and emotional activities.*

Pain and fever are most effectively alleviated by the administration of salicylates, preferably acetyl salicylic acid or aspirin. It is felt by many observers that the salicylates exert only an analgesic and antipyretic action, without any direct effect upon the disease. However, it is a common observation that the tachycardia and the sedimentation rate are reduced by salicylate medication. Furthermore, clinicians generally agree that the administration of salicylates reduces the symptoms of active rheumatic fever. The withdrawal of salicylates is often followed by a recurrence of rheumatic fever activity, evidenced both clinically and by laboratory findings. It would seem therefore that the salicylates may have a suppressive action and perhaps some direct anti-inflammatory effect upon the pathological process.

No arbitrary rule of dosage of salicylates should be employed. Rather the severity of the disease and the therapeutic response in each individual case determines the effective dosage. The oral administration of salicylates is very effective and safe. Salicylate intoxication is rarely encountered. The intravenous administration of salicylates is not to be recommended.

The treatment should be instituted as early in the disease as possible and extended well into the convalescent and latent period.

The effect of ACTH and cortisone simulates that of salicylates, bringing about decrease in temperature and sedimentation rate and relief from pain in a rapid dramatic way, together with a variety of untoward toxic manifestations. Some of these side reactions are reversible, disappearing upon the withdrawal of the drug, others are persistent and may seriously complicate the situation. Patients responding to the administration of ACTH and cortisone experience, on the withdrawal of the drug, a "rebound" or reactivation of the rheumatic process more often and to a greater degree than those treated by salicylates.

The decrease in morbidity, recurrence and mortality of rheumatic fever experienced during

the past fifteen years speaks well for the effectiveness of the empirical basic treatment and suggests that our concept of the disease is rational.

The prevention and limitation of streptococcal infections by the judicious employment of penicillin and sulfadiazine offers a reliable method of combatting the occurrence of primary as well as recurrent rheumatic fever.

At the present time the use of ACTH and similar hormones cannot be recommended as a routine treatment of rheumatic fever.

Salicylate seems to be the drug of choice and should be employed early and continuously throughout the management of rheumatic fever.

SUMMARY

The etiology of rheumatic fever still remains unknown.

The relationship between hemolytic streptococcal infections and rheumatic fever appears to be established and the reduction of such infections is associated with a decrease in incidence and recurrence of rheumatic fever.

The prevention of initial as well as recurrent attacks of rheumatic fever by judicious use of antibiotics under careful supervision has proven highly successful.

The value of good hygienic care and attention to the emotional needs of the patient is a big factor in recovery.

Salicylates are still the drug of choice in the treatment of rheumatic fever.

The use of A.C.T.H. and cortisone is not encouraged as a routine measure.

The Physician as a Witness

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Medical men have occasion to appear in court as witnesses in two capacities, and for two rather widely varing purposes.

They may be called as ordinary witnesses, in which capacity they are expected to testify regarding facts which have come under their observation relative to the cause on trial. Or they may be called as expert witnesses to render opinions or to clear up the medical aspects of the case on trial, either proven or assumed.

The attendance of physicians when called as ordinary witnesses, and sometimes when called as expert witnesses, is usually obtained by the service of a subpoena. If the witness is required to bring documents, records or papers in his possession or under his control, this writ takes the form of a subpoena duces tecum. The subpoena duces tecum must describe the documents required with such reasonable detail that the witness can understand what is wanted.

Failure to obey the subpoena is punishable, as it constitutes contempt of court. In some states, the person who fails to obey a subpoena may also be held legally and financially liable for such damages as may be sustained by the party in whose interest he was called to testify. In some states, this liability is the subject of special statutory enactment and the liability imposed is a further penalty.

Privileged Communications. — In a considerable number of states, all knowledge obtained from patients by physicians acting in their professional capacity is privileged. As such, it may not be disclosed without consent of the patient or some one authorized to represent him or her. It is important that physicians practicing in states which have privileged communication laws be familiar with their rights in this regard.

As far back as history goes, it has been considered good public policy that certain matters be sacred and kept secret, and these have been protected from public disclosure. Matters in this group may be classed under the four following heads, namely: Political matters, such as communications between heads of governments; The so-called state secrets; judicial matters, such as consultations between judges and deliberations in the jury room; professional matters, such as communications between attorneys and clients and between physicians and patients; and social matters, such as confidential communications between husband and wife. In more than half the states, communications between phy-

sicians and patients are privileged and protected from inquiry, and physicians are forbidden by law to disclose them in or out of court.

In some states, the privilege is automatically waived if the patient voluntarily testifies regarding the subject matter of the communication, and the physician is thereby released from secrecy in that particular matter.

It is worthy of note, that privilege can be invoked only by licensed physicians, and then only when the relation of physician and patient has existed. There are numerous instances in which physcians have examined persons for the purpose of securing information with the sole intention of testifying regarding their findings. In these instances, it is definitely understood that such examinations are made for the purposes stated and not for professional treatment and that the information secured at that time and in that manner, may be disclosed on the witness stand.

Peculiar and interesting complications occur with regard to privileged communications. In a personal injury case, reviewed by the Supreme Court of Washington (164 Pac. R. 71) a physician, who had attended the plaintiff as her physician, was asked to describe the nature and extent of an examination which he had made while the plaintiff was a patient in the hospital under his care, but he was expressly forbidden to state what his findings were in that examination. After answering those questions, he was asked whether he had made two subsequent examinations of the plaintiff. He replied that he had, not as her physician or for the purpose of treating her, but to enable him to testify as an expert witness regarding her condition. He was then permitted and required to testify regarding his findings at the later examinations, because at these times he was not acting as her physician, and the knowledge elicited was not privileged.

Two other examples of some of the peculiar workings of the privileged communication laws occurred in my own experience. While in general practice in Nebraska some 46 years ago, I attended a patient whose heirs subsequently sued an insurance company for life insurance carried by the patient. In the interval between her death and the time of the suit, I had moved to Chicago. Nebraska would not have permitted me to answer some of the questions under their strict privilege communication law; but in Illinois no such law existed.

The other instance worked exactly the opposite. I had examined a woman in Chicago, who alleged that she had been injured in Nebraska, and because the examination was made outside of Nebraska, I was subpoenaed while visiting in Omaha and required to testify regarding my findings.

The fact that a physician is employed by an individual, a hospital, corporation, a public institution or any other third party does not, in the absence of a special statutory modification, prevent the operation of the privilege as regards these communications. That also holds regarding physicians who have been called as consultants when such consultation is for the purpose of making a diagnosis or in the course of the treatment of disease or illness. But, as a general rule, information elicited as the result of an autopsy or the subsequent microscopic or chemical examination of or on the remains, is not held to be privileged.

It must *not* be understood that the laws and statutes regarding privileged communications are for the protection of the medical profession, *because they are not.* They are exclusively and entirely for the protection of the patient. It is the physician who is forbidden to give out the information unless the privilege is waived by the patient, his guardian, next friend, conservator or administrator. In some states this privilege may not be waived by the heirs or administrator.

It must be noted that communications for or during the commission of a crime or other unlawful act are not considered amenable to the privilege and are therefore not protected. Under this head are consultations for the procurement of criminal abortions. Likewise, when a physician is facing prosecution for the murder of a patient or for the commission of any crime by him upon his patient, matters between the accused and the patient are not privileged. But in ordinary criminal actions the privilege applies, as it does in ordinary civil matters.

It has been decided in several states that, when a patient sues a physician for malpractice, such suit constitutes a waiver of the privilege. But when a physician sues a patient for the amount of his fees and the patient enters a gen-

eral denial, thus placing the burden of proving the services upon the physician, he does not waive the privilege. While logically it appears that such plea on the part of the patient should substantially be a waiver of the privilege, it is generally held that such is not the case.

Testifying. — In the giving of testimony as a witness, after being sworn by an officer of the court, the manner of procedure may vary slightly in different states. It usually begins with questions regarding his qualifications, asked by the attorney for the party in whose behalf he was supoenaed. The witness may be asked to relate in narrative form the facts as observed by him, or he may be asked questions to which he is to make reply. The latter method is the one in most general use, because it leads to the introduction of the more salient and important facts and to the omission of unimportant and irrelevant matters.

When testifying as an ordinary witness, not as an expert, the physician must testify as to the facts of the case, and must not give opinions or inferences. Only expert witnesses are permitted to give opinions or inferences.

At any time during the examination, the judge may, on the request of the attorneys for either side, require that all ordinary witnesses be excluded from the court room, so that they cannot hear the testimony given. This does not as a rule hold true in regard to expert witnesses.

Likewise, at any time during the examination, the judge may ask the witness any questions, which he may consider necessary to bring out facts relevant to the case.

After the direct examination of a witness, the other side is privileged to cross-examine him. The general rule regarding cross-examinations, followed in nearly every state, is that questions asked a witness during cross-examination must be limited to the facts brought out by that witness' testimony during direct examination. Trial judges, however, generally allow a wide latitude regarding this.

It is during cross-examination that many witnesses fail to render a good account of themselves. Many become excited, confused and irritated and, too frequently, because of the mental disturbance, contradict their previous testimony or make statements which they do not intend and which they would not make under ordinary conditions.

Many trial lawyers make it a practice to intimidate and brow-beat witnesses during cross-examination to get the witness excited, irritated, confused or unnerved. The degree to which this is allowed or the extent to which cross-examination may be prolonged is largely a matter of the discretion of the court. Nearly all judges will protect witnesses from unnecessary abuse from attorneys, their insinuations or innuendos, if the witness shows inability to protect himself. The better attorneys do not insult witnesses or make their examinations a contest of wits and nerve between lawyer and witness. Unfortunately, however, there are some lawyers whose principle strength lies in their ability to confuse witnesses unless the witnesses are of unusually even temper and able to maintain self control.

Frequently, during the examination of witnesses, lawyers interpose objections and exceptions and otherwise interfere with the replies of the witnesses, in more or less legal and often more or less improper ways, so that the witnesses are interrupted and may become confused. Often that is the sole purpose of these interferences. The witness should be on guard against such practices and keep complete control of his temper.

Some forty years ago I was being cross-examined by a very able but notoriously abusive lawyer in a criminal case in which I was appearing for the state. This lawyer and I were friends of several years standing and he knew he would have a difficult time to excite me. He persisted in shaking his long fingers under my nose in a threatening manner until I said: "Mr. —, if you do not take your fingers away from under my nose, I will bite them", which disconcerted the lawyer and convulsed all those present in the court with laughter.

After the laughter had subsided, I added: "On second consideration, I do not think I will bite your fingers. They are too dirty." That finished my cross-examination. The judge declared a recess and while walking out of the court room, the lawyer affectionately put his hand on my shoulder and said that he had never been so disconcerted in his life. However, when he was summing up the testimony at the close

of the trial, he told the jury that one of the state's witnesses was so prejudiced against his client that he had threatened to bite his fingers.

If a witness fails to understand clearly the question asked him, or its disturbed or confused by interruptions, he would be wise to make no effort to reply until the question is made clear. One or two such repetitions, if the disturbance is intentionally caused by interference by attorneys, will usually cause the attorneys to desist and adopt different and less disturbing tactics.

Phraseology. — It is generally best to confine all medical testimony to common language and ordinary words and to eschew and keep as much as possible away from technical phraseology. A witness who clothes his answers in language which will be understood by the least educated person on the jury will reach the most intelligent person as well, and the testimony will have greater weight if it is understood. It will, in that way, be far better received and more credance given to it than if it is couched in long polysyllablic ultrascientific phraseology.

INABILITY TO ANSWER. — Physicians are far too prone as witnesses, to fear to say, "I do not know". They fail to remember that no one person can possibly know all there is in medicine.

As a witness many times, both as ordinary and expert witness, (mostly the latter) the writer has never hesitated to confess ignorance, if such was the truth. Many times attorneys have commented upon the increased weight such testimony has carried, because of this candor. Anyone is bound to believe a man who will admit that he does not know, and much more reliance is placed on anyone who recognizes his limitations and does not claim to know it all.

In reply to an orthopedic surgeon in California who asked some questions in December 1941, I wrote as follows: "I have several times discussed 'expert witness" and 'expert testimony' before physicians and lawyers. My advice to physicians has been that whenever a physician or surgeon is on the witness stand as an expert, he should use his utmost effort to discard his professional manner and to recognize that it is his duty and function to make the jury understand what he is saying in the testimony he is giving. He should, as nearly as possible, use language that will be understood by everyone in the jury, and when it is necessary to use technical terms, he should explain them. Big words and high sounding phraseology do little more than throw up a cloud of scientific fog and do not convince the jury, judge or anyone else.

"Personally, it has been my habit (and I advise others to do likewise) to use words of one syllable, even when giving testimony before judges and arbitrators, because, while they may have plenty of learning and education in their own lines, most of them are not familiar with medical terminology. The average jury is made up of men and women with the average, or less than average I.Q. If we talk over their heads we defeat our purpose in appearing as a witness.

"Another important thing to remember is to talk to the jury, even if you are answering questions asked by the lawyers. If you are at all inclined to be disconcerted or flustered by the lawyers, this facing the jury and talking to them will, in a large measure, tend to obviate becoming nervous or upset. Another point to remember is that you know much more about medicine than does the lawyer, and *he knows that you do.* Consequently you have an advantage over him if you keep this in mind.

"A witness should always endeavor to be polite and courteous in answering questions. This should hold good just as much to the questions put to him by counsel for either side of the case and to questions asked in cross-examination. If attorneys try to confuse you, remember that they are trying to get you angry or confused so that you may either contradict yourself or make some remark that is the result of anger or pique.

"Nothing pleases a lawyer as much as to be able to embarrass a witness who is appearing for the other side of the case, and nothing makes a lawyer more unhappy than to see one of his witnesses fussed or angry. It is well known that once a witness is angry or loses his composure, he is liable to become reckless in his replies or attempt to say things which he considers clever.

"The ideal witness is calm, composed and courteous with all with whom he comes in contact in the court room. He is serious in manner because he realizes that law suits and trials are serious matters. One need not forego smiling, when something justifying a smile occurs, but it is best to be serious when answering questions. One need not be doleful or lugubrious: but one should not appear happy or jubilant even when

you find you have answered a question that has added force to something you have said before. Be matter-of-fact and your testimony will have a much greater effect upon the jury, and it is the jury you must impress if you are going to do any good for the side for which you are appearing.

"Above all things, do not try to favor either side of the case strongly. Do not be an advocate. That position belongs to the attorney. Remember that you are on the witness stand in a court of law, and that you are there because you know certain things. Be a witness only, and if you have told the truth as you see it, stick to it and do not be led into doubting or modifying what you have said. It is easy not to be contradicted or not to contradict yourself if you have told the truth."

25 East Washington Street, Chicago 2.

Diaphragmatic Hernia

A Report on 103 Cases

George D. Lavers, M.D.* and Charles D. Branch, M.D.,**
Peoria

There have been many excellent articles recently on the subject of diaphragmatic hernia. Undoubtedly this condition will be seen with increasing frequency. The life span lengthens constantly, creating more elderly persons in whom the most common, the hiatus type, is seen. Automobile accidents, the prevalent cause of the traumatic type, continue to multiply. However, this diagnosis is often overlooked clinically. We have no new suggestions with regard to treatment, but by a review of the clinical picture and roentgenographic findings in 103 cases seen in five years from 1946 through 1950, we hope to emphasize the symptoms which should suggest this diagnosis.

CLASSIFICATION

Standard methods of classification differ little from one another. The one presented is that of Harrington.[1]

I. Non-traumatic:
 1. Congenital — at birth
 a. Through foramen of Bochdalek (hiatus pleuroperitonealis).
 b. Esophageal hiatus.
 c. Through foramen of Morgagni.
 d. Through absence of diaphragm.
 2. Acquired after birth
 a. Through esophageal hiatus with sac.
 b. Through region of the fusion of anlages of the diaphragm.
 c. Through the sites of congenital hernia.

II. Traumatic
 1. Indirect — by crushing injury.
 2. Direct.

Our cases naturally fall into three main groups under which, for convenience, we will discuss them:

I. Newborn.
II. Adult exclusive of hiatus hernia. (Including eventrations).
III. Adult hiatus hernia.

METHOD

Data on these cases were collected from three sources:

1. Post-mortem records.
2. Roentgenographic reports.
3. Case histories.

When possible, information from all three sources was integrated.

RESULTS

In this five year period, the diagnosis was

Read before the Northern Tri-State Medical Association, Toledo, Ohio, April 17, 1951.

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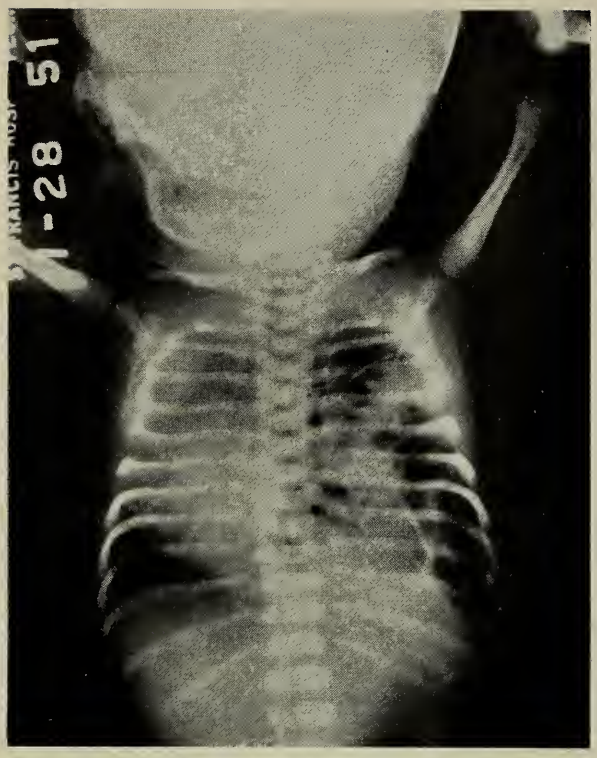


Figure 1.—Massive congenital diaphragmatic hernia with mediastinal shift. Infant did not survive surgery.

established on 103 patients. Of these, 100 were adults and 3 were newborn.

Post-Mortem Records—

The reports on the 1,238 autopsies performed in these years were carefully reviewed for evidence of diaphragmatic hernia. Seven cases were found, an incidence of 0.56%. Three of these were newborn on whom the diagnosis was made only by autopsy. In the four adults, x-ray had demonstrated the hernia in all.

The findings on the adult post-mortem examination showed that only one death could be attributed to the hernia. This patient died on the 7th post-operative day of a pulmonary embolus. The other three deaths were due to other causes and the diaphragmatic hernia was an incidental finding. This low percentage is due probably to post-mortem shrinkage with reduction of the hernia, and to the fact that many are so small as to be easily missed without special attention.

Roentgenographic Reports—

The diagnosis was made by x-ray 106 times:

105 by G-I series.

1 by chest film.

Of the 105 diagnosed by G-I series, 4 were examined twice and 1 three times. Thus the diagnosis was made on 99 patients by G-I series and on 1 by chest film. During the 5 years, 5,018 G-I series were performed, some of which were repeat examinations of the same patient. The gross incident then was 105 in 5,018 or 2.09%.

On the chest film, occasionally a gas-filled viscus with or without a fluid level may be seen above the diaphragm. However, most diagnoses are made by barium swallow in the head-down position.

Case Histories—

Review of the charts and histories on all inpatients provided a complete picture of this group. Those in whom this was an incidental finding were checked by references to the x-ray cross-index.

NEWBORN DIAPHRAGMATIC HERNIA

Three cases were diagnosed by autopsy on newborn infants. Most of these are massive and incompatible with life (Figure 1). Probably very few adults diaphragmatic herniae are congenital in origin. All of our series died shortly after birth — one at 15 minutes, one at 30 minutes, and one at 3 hours of age. In each the defect was large, two on the left and one on the right. The protocols do not state through which of the foramina the herniation occurred. Other congenital anomalies were present in two — four thin-walled mediastinal cysts in one and a horseshoe kidney in the other.

ADULT NON-HIATUS DIAPHRAGMATIC HERNIA

In our cases, six were reported on x-ray as being probably not hiatus in type. Each was massive and in three the possibility that they were eventrations was noted. Eventration is a congenital condition, not a hernia, in which the diaphragm is very thinned out, rises high in the chest, and does not move well. The differentiation between a hernial sac and a thin eventration of the diaphragm is very difficult on x-ray. In one of these, surgery later proved it to be a hernia, not an eventration.

Of the other three, those not called eventrations, one on the left contained stomach and three on the right contained colon (Figures 2 and 3).

HIATUS HERNIA

Sex Incidence—

Females — 48

Males — 46

94

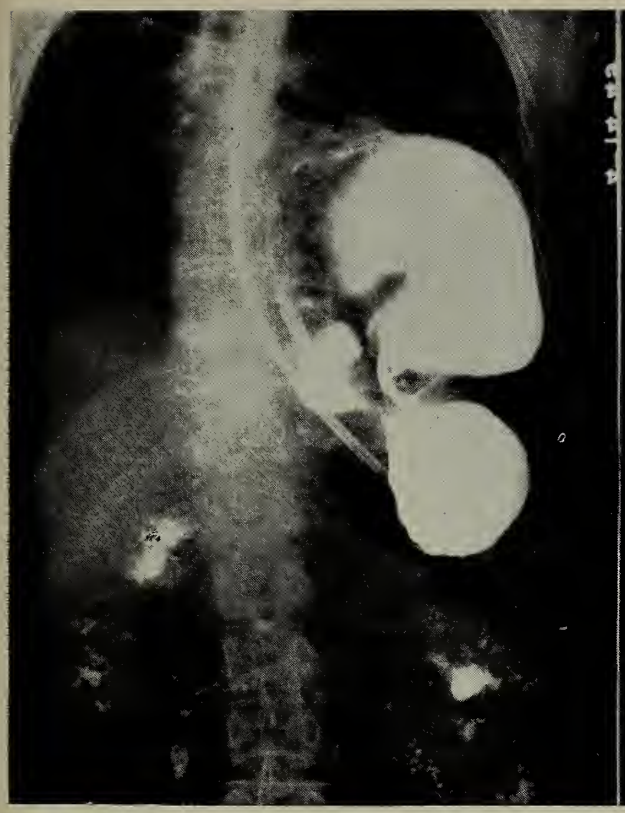


Figure 2.—Large left sided hernia containing stomach. The so-called "upside-down stomach".

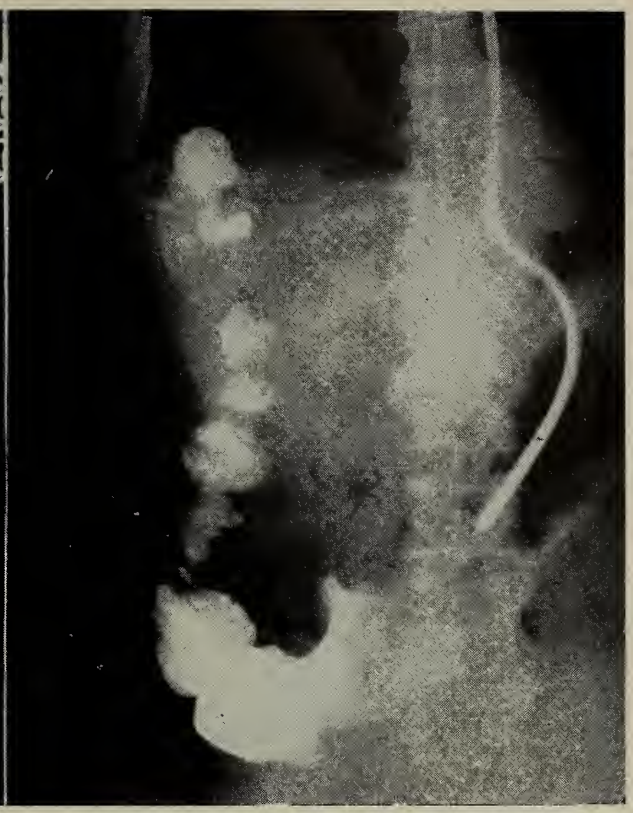


Figure 3.—Right sided hernia containing hepatic flexure of colon.

Age Incidence—

The youngest in this group was 22, the oldest 88. There was a significant difference in the age of the two sexes. The highest incidence in females occurring at an age nearly 20 years older than the males.

	20-29	30-39	40-49	50-59	60-69	70-79	80-
Male	0	1	7	16	11	9	2-46
Female	1	0	3	11	13	15	5-48

Size of Hernia—

In about one-half of the cases x-ray report gave the size of the hernia in centimeters. In the rest, it was described merely as small or large. By cross-checking this use of terms, a rough grouping can be made.

	Patients	*Percentage*
Small, up to 3 cm. inclusive	44	46.8%
Medium, 4 to 6 cm.	30	31.9%
Large, 7 cm. and over	20	21.3%

Short Esophagus—

In 1926, Akerlund[2] classified hiatus hernia into three types:

Type I — Para-esophageal hiatal hernia. Esophagus of normal length and joins the stomach in normal position.

Type II — Sliding or gastro-esophageal type. Esophagus of normal length with the lower end of the esophagus as well as the stomach herniated, but the esophagus enters the stomach normally on its lesser curvature (Figure 4).

Type III — Short esophagus with partial thoracic stomach. The esophagus enters the highest point of the herniated stomach (Figure 5).

On review of the x-ray reports, one comes to the conclusion that these three types are not definite, but are artificial separations of a gradual gradation. It seems reasonable to assume that attachment of the lower end of the esophagus is the main differentiation of Type I from the others. If the attachment remains to the ring, only the stomach can herniate. If the esophagus also takes part in the herniation, because it is a muscular organ, it would seem to be only a matter of time until it becomes shortened. Thus, the difference between Type I and Type III would indicate how long the esophagus had

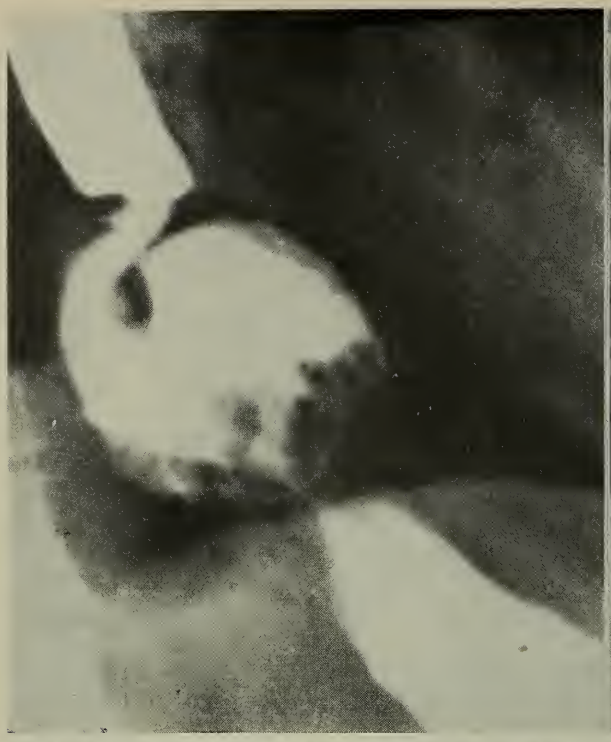


Figure 4.—Normal length esophagus entering herniated stomach.



Figure 5.—Short esophagus.

been detached and the degree of shortening resulting (Figure 6).

The term congenitally short esophagus has sometimes been used loosely for all cases of short esophagus. Such a condition undoubtedly exists because it has been shown in young children. But in an adult, the only proof would be x-rays showing its existence as a child or persistence of symptoms from childhood. This is very rare. Harrington[1] estimates that less than 4% of cases of short esophagus seen in adults are truly of a congenital type.

Symptoms and Complaints—

The x-ray reports were most useful in this review. The department maintains a very accurate cross-index file by which all primary and secondary diagnoses can be quickly reviewed. In addition, the radiologist or his resident takes a concise history concerning the system affected. On the out-patients this was the source of all our information. On the in-patients, it could be used to supplement the history.

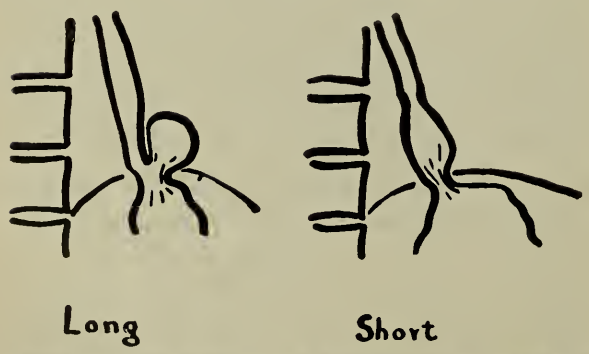


Figure 6.—Diagrammatic representation of difference between hernia with short and with normal length esophagus.

An attempt has been made to group symptoms, which in the patient's words seemed to fall in the same group. Symptoms in order of frequency:

Epigastric Distress	54
Vomiting	40
Chest distress	24
Discomfort after meals	21
Nausea	21
Flatulence	20
Constipation	14
Loss of weight	14
Relief with alkalis	13
Vomiting blood	13
Aggravation lying down or at night	12
Distress from solid food	12
Belching	11
Melena	9
Anorexia	7
Sour taste	6

Dyspnoea after meals	6
Diarrhea	6
Pain left shoulder or arm	6
Relief sitting or standing	5
Anemia	4
Sweating after meals	4
Relief drinking liquids	4
Radiation both arms	2
Radiation right shoulder or arm	2

The grouping of these complaints into those which are related to each other rather than in strict order of frequency gives us more detailed information as to the symptom complex.

1. Distress — The general term distress has been used to include various complaints. The history often said pain, however, it seemed from the details that it was not severe enough to be a pain. When the patient's own words were quoted, the terms most often seen were "burning" and "heartburn". With 54 giving this as the primary complaint, it is the most important symptom.

 Location — It was always described as a deep sensation. The site varied from epigastric to lower thoracic, the point of centering being most commonly sub-xiphoid. It was always midline. In 24, it was located in the lower chest.

 Time — Most often it was with or after meals. If during meals, sometimes it was produced by solid food and not by liquids, or relieved by liquids. This type is probably due to obstruction from spasm or stenosis or angulation at the ring. If after meals, it was from ½ to 2 hours later, like ulcer pain, and probably from irritation of retained food or excess acidity.

 Radiation — Radiation was uncommon. When present, it was more common to the left shoulder or arm. Possibly from phrenic radiation.

 Relief — was obtained in some instances, 13, by antacids and ulcer regime. In others, by drinking as noted above.

 Position — when present, the positional effects were typical and nearly diagnostic, the upright position allowing emptying and relief, and lying down or going to bed causing persistence of discomfort.

2. Vomiting and Nausea. Just as the distress may be irregular with free periods of weeks or months, so may the vomiting which was more common than nausea. Just as with any hernia, when the viscus is "out", symptoms are present.
3. Flatulence was noted by 20 patients and relief following belching by 11. Sour eructations were noted at the same time by some.
4. Anorexia and loss of weight was present in several. Significantly more noted the loss of weight than the reason for it, the anorexia. They avoided solid foods and decreased the quantity to avoid discomfort without knowing they were doing so in many instances.
5. Vomiting of blood was noted by 13, a seemingly high incidence, and melena by 9. Presumably these were due to ulceration. Anemia was known to be present in 4.
6. Constipation and diarrhea. These older people are frequently constipated and so the relation to the hernia seems doubtful.
7. Dyspnea and sweating after meals. These often occurred together when present. A feeling of weakness might also be present.

Associated Diseases—

A very interesting result of this survey was the compilation of other diseases known to be present in this group. Exclusive of unrelated conditions such as arteriosclerosis and diabetes, which are associated with advancing age, but which have nothing to do with confusion of symptoms, the commonest associated diseases in order of incidence were:

1. Gall-bladder disease. Of the in-patients, 28.1% had previous cholecystectomy or were proven to have chronic cholecystitis or gallstones. 12% had had cholecystectomy; and yet returned for x-rays after operation. Thus, one cannot avoid the conclusion that many of these patients had had cholecystectomy for symptoms which were originally due to the hernia.
2. Duodenal ulcer. This was present or had been present and healed in 14.8%. This is the higher percentage than expected for this age group. In addition, many without proven ulcer obtained relief from ulcer treatment and had been clinically diagnosed as ulcers. Harrington considers ulcer a possible cause of the hernia. The reverse, ulcers from vagal

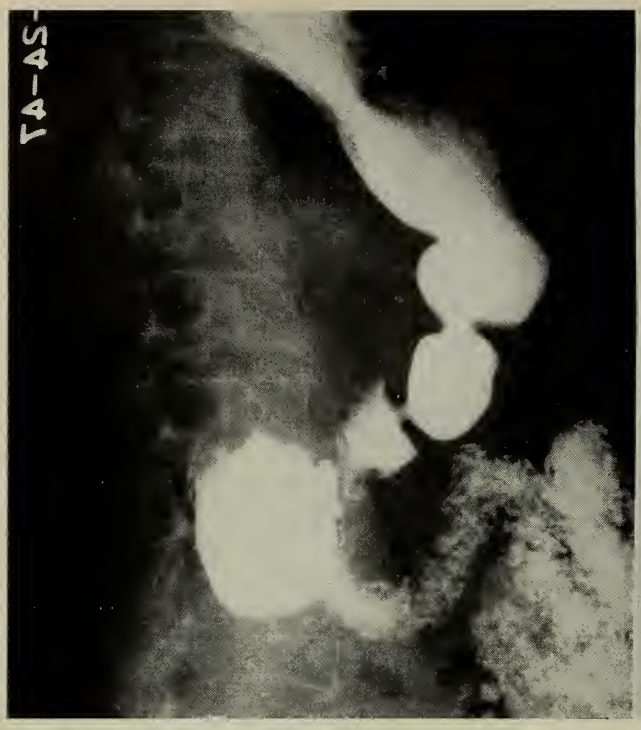


Figure 7.—Diagrammatic hernia and large diverticulum from second portion of duodenum.



Figure 8.—Diaphragmatic hernia and two esophageal diverticuli.

stimulation and hyperacidity caused by irritation of the hernia, also seems possible.

3. Diverticulosis of the colon was present in 10 cases. This probably is compatable with this age group. It and the hiatus hernia are both due to muscular and fascial relaxation.
4. Duodenal diverticuli present in 9 (Figure 7).
5. Esophageal diverticuli in 4 (Figure 8).

Admitting Diagnosis—

The admitting diagnosis or the clinical diagnosis sent with an out-patient to x-ray gives the diseases for which this condition may masquerade. However, in some, an error could not be assumed. If the diagnosis was gall-bladder dysfunction, and that as well as the hernia was discovered, the former could not be listed as a mistaken diagnosis. The most common errors were:

1. Gall-bladder disease.
2. Peptic ulcer.
3. Heart disease — most commonly angina pectoris and coronary occlusion. No patient diagnosed as acute coronary disease was proven to have had such a lesion.
4. Carcinoma of the stomach or colon. In these older people, a malignancy must be ruled out. In this group in addition to the hiatus hernia, three had carcinomata of the colon, one of the pancreas, one of the stomach, and one of the stomach at the site of the hernia.

COMPLICATIONS

The common complications of diaphragmatic hernia are:

1. Strangulation.
2. Ulceration.
3. Hemorrhage.
4. Malignant changes.

These are all very rare complications. All newborn, massive, and traumatic cases should be operated upon because of the danger of strangulation. Ulceration and hemorrhage are rarely serious. Carcinoma may occur in the herniated fundus of the stomach. Whether it is related to the hernia or coincidental, is unknown.

Composite Clinical Picture—

From our compilation of symptoms, it is valuable to draw a picture of the typical case. Hiatus hernia is present most commonly in men or women in the age group over 50 years. The chief complaint is a burning distress centered around the region deep to the xiphoid. It is related to meals. There may be a sensation of solid food becoming "stuck" at this level with relief on taking liquids. Following the meal,

there may be a feeling of fullness relieved by belching and accompanied by sour eructation; or the sensation after meals may resemble ulcer pain. When present, the story of relief by sitting or standing and aggravation on lying down is important. Vomiting and nausea may be present and there may be blood in the stool or vomitus. As a result of discomfort from solid food, the patients become anorexic and lose weight. Radiation is not common, but when it does occur, it is more likely to the left shoulder. The most common clinical conditions likely to be confused in diagnosis are gall-bladder disease and peptic ulcer.

TREATMENT

From review of these cases, it would seem too radical to state that all diaphragmatic herniae should be repaired. The mortality in this group of old people would not be negligible at best. Treatment then in brief is as follows:

1. *Medical Treatment*— With the small hiatal herniae, most people find the best method of obtaining relief for themselves — eating slowly, not taking a large bolus of solid food, drinking with meals, antacids and maintenance of the upright posture after meals.
2. *Surgical Treatment*—
 Mandatory — in three groups:
 1. Newborn.
 2. Massive herniae in adults with danger of strangulation.
 3. Traumatic herniae.

 In all these, surgical repair should be carried out when diagnosed.

Elective—

Surgical treatment for the smaller herniae with no danger of strangulation is purely to obtain comfort. If medical means fails, phrenicotomy may allow relaxation of the diaphragm and give relief. Since this is a simple procedure, its use should be more frequently considered. In those patients in which this fails to relieve the symptoms, repair may be indicated.

SUMMARY

1. Diaphragmatic hernia is being recognized more frequently and is not as rare as once thought. In five years, 103 cases were seen in this hospital.
2. The clinical diagnosis is still not made often enough. Analysis of these cases discloses a group of symptoms which when present, should suggest the diagnosis of diaphragmatic hernia.
3. The esophageal hiatus type seen in elderly persons is the most common.
4. The treatment has been outlined.

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The Effect of Pregnancy on Disease

S. Howard Armstrong, Jr., M.D., Professor of Medicine, Moderator; Frederick H. Falls, M.D., Professor of Obstetrics and Gynecology; Robert W. Keeton, M.D., Professor of Medicine, Emeritus; Meyer R. Lichtenstein, M.D., Clinical Assistant Professor of Medicine, and Oglesby Paul, M.D., Clinical Assistant Professor of Medicine.

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Dr. Armstrong: It is generally agreed, I believe, that pregnancy is a state of health. Yet the expectant mother shows profound changes in the biochemistry of her body. It is difficult to understand, indeed, how the requirements of the growing foetus can be met while the body of the mother at the same time maintains a comparative state of normality. As one must expect, the regulations which control pregnancy are delicate and easily disturbed when extraneous factors upset the sensitive balance. Disease affects pregnancy, but almost more so, pregnancy affects disease. Dr. Falls will present the review of how pregnancy is complicated by inetrcurrent illness.

Dr. Falls: In the order of frequency, pregnancy is always a problem in patients with nephritis. In order that they may carry through nine months of additional strain, one must decide when the life of the mother is in danger due to the underlying kidney disease, and when it is advisable to abort a pregnancy, or to carry it through to completion. If the kidneys seem to fail early in pregnancy, an abortion may be necessary. In nephrosclerosis and in chronic glomerulonephritis, the additional fetal load usually becomes apparent very early in pregnancy, and the functional capacity is soon reached, and either nature aborts the fetus, or obstetrical interference is required. If, however, the patient's kidneys show ability to handle the extra load, the pregnancy is allowed to progress to viability of 32 weeks and the pregnancy is completed by Caesarian section and the patient sterilized.

Frequently, secondary to uterine pressure caused by the enlarging uterus, pregnant women will develop a pyelitis. Although the pyelitis itself is a local therapeutic problem, these people develop a type of self-immunity to the organisms and it is rarely necessary to terminate a pregnancy because of pyelitis. I have never seen puerperal sepsis in a patient who has had a pyelitis pregnancy in spite of the obvious contamination of the vagina during labor by the organisms causing the pyelitis.

Other less common renal problems are those of occasional abdominal masses which are found to be ectopic or abnormally placed kidneys. Tuberculosis of the kidney is another occasional complication. If nephrectomy was performed for tuberculosis before the pregnancy started, it can in most cases be allowed to continue.

Poliomyelitis is a dangerous and frequent complication of pregnancy and the obstetrician is frequently required to intervene during this disease, especially if it is the bulbar type.

Cardiac complications are usually considered dangerous due to the oxygen efficiency that may develop during pregnancy. The problem is to get sufficient oxygen to both mother and fetus. Recently, therapy of cardiac complications has become more conservative, and the patient is frequently allowed to complete the first stage of labor which she frequently does without decompensation, and she is then helped with forceps or version during the second and third stages. The cardiac complication that we fear the most is the patient with mitral stenosis, or the patient in her 30's with a congenital heart who, by the way, frequently will have difficulty even two to three weeks postpartum.

The occurrence of carcinoma in a pregnant

cervix is a potentially fatal complication, since pregnancy will increase the rate of spread of the neoplasm. Even if the fetus is destroyed, the mother will still have a potential fatal outlook. We do not want this type of patient to undergo labor because the contractions of the uterus in labor enhances the lymphatic spread of neoplastic cells of the involved cervix. In the early stages of pregnancy, we may disregard the pregnancy and do a complete hysterectomy. But if the diagnosis is made late in pregnancy we attempt to obtain a viable baby and leave the uterus in place for radium implantation. We treat six weeks with x-ray and then do a hysterectomy and follow up with x-ray.

Syphilis, of course, has recently been less of a problem since the advent of antibiotic therapy. The primary lesion is frequently difficult to find, but once it is determined, the administration of therapy is no problem because prior to the fourth month, the spirochete does not penetrate the placenta. Gonorrhea may occur with pregnancy and when the cervix dilates and the fetus descends and is delivered, a generalize peritonitis may occur if treatment is not promptly instituted. Cholelithiasis late in pregnancy when an elevated diaphragm is already present, must, in most cases be treated conservatively and palliatively. Early in pregnancy treatment can be instituted as if the patient was not pregnant. Pulmonary tuberculosis is always of great concern to the obstetrician, although the fear that we used to feel has decreased somewhat. We have found that we can frequently carry these people through pregnancy. Sudden decompression of pulmonary activities following the descent of the diaphragm postpartum can be controlled by increasing intra-abdominal pressure with abdominal binders and other techniques. If empyema is present this can be readily managed by drainage without effecting the pregnancy. Asthma may also offer some complications, especially with seasonal allergies when we may be forced to place these people in rooms with filtered air. During an asthmatic attack or in late pregnancy when the lung area is compressed, the presence of decreased available lung tissue for respiration may cause difficulty. This is also true in pneumonia where aeration again is a problem. If delivery should occur during an acute pneumonia, contamination of the genital tract may lead to pneumonic peritonitis.

Occasionally we see people with rectal bleeding and hemorrhoids secondary to uterine compression resulting in bleeding and a neoplasm of the gastrointestinal tract must frequently be ruled out.

Dr. Armstrong: Thank you, Dr. Falls, for summing up how disease complicates an existing pregnancy. We have selected three areas of medicine to discuss how pregnancy complicates in turn an existing disease. Dr. Keeton will present a review of the effects of pregnancy on diabetes, Dr. Lichtenstein on the nervous system, and Dr. Paul on cardiovascular disease.

Dr. Keeton: Carlson has shown that pregnancy in dogs ameliorates pancreatic diabetes. If a pregnant bitch is pancreatectomized late in her pregnancy, diabetes becomes manifest but the pregnancy is carried to term. Following delivery the diabetes increases in severity and death ensues. He concluded that the pancreas of the fetus replaced some of the insulin, which had been previously supplied by the maternal pancreas. Doctors familiar with his work are often disturbed because this mechanism in not effective in clinical diabetes.

The mechanism involved in the production of diabetes mellitus is different. Pregnancy actually aggravates clinical diabetes. Thus 5% of women with diabetes develop it during pregnancy. A woman not previously know to have diabetes may manifest it during pregnancy, require insulin for her protection, and after delivery return to a state of mild diabetes detectable only by a diabetic type of glucose tolerance curve.

A previously known diabetic will find her insulin requirements increassed during pregnancy. It is now generally agreed that diabetes mellitus results from the exhaustion of the islet tissue due to increassed demands for insulin. This mechanism was most clearly shown by Long in the case of partially depancreatectomized rates. They showed no diabetes until they were rendered hyperphagic by symmetrically placed electrolytic lesions in the hypothalamus. Afterwards they often trebled their intake of food in the course of a day. Unless food was removed from the cages prior to the anesthesia used to place the lesions, they would

choke to death on it during their recovery period. These animals became extremely obese and developed diabetes from the exhaustion of their supplies of insulin which were used to convert the carbohydrate into fat. I am sure that we can all recall associates who, like the rats, are eating themselves into obesity and diabetes.

The growth hormone appears to be increased in pregnancy. The large babies of women with latent and manifest diabetes are in part due to this factor. The diabetogenic factor which was first recognized in extracts of the anterior pituitary comes out with the growth hormone in the process of purification. However, the more highly purified growth hormone products of today do not produce experimetal diabetes. In addition to the diabetogenic factor the extra calories (20%) require by the pregnant woman and the increase in appetite produced by the pregnancy, combine to exhaust the supplies of insulin.

The low renal threshold for glycosuria in pregnancy has made difficult the clinical adjustment of the insuiin dosage to the patient's requirements without producing dangerous reactions and miscarriages. This low threshold has been attributed to a decrease in the tubular resorptive capacity, such as follows the use of phlorhizin. It now appears more probable that it is due to an increased glomerular filtration rate secondary to an increased blood volume and arterio-venous shunts in the placenta. The practical indication for the elevation of the dose of insulin is the presence in the urine of acetone rather than sugar.

The death of the fetus in late pregnancy seems to be associated with a disproportion between the chorionic gonadotropic and estrogen contents of the blood, and the extent of maternal arteriosclerosis. The ease with which edema appears suggests that an adrenal factor may be involved. The administration of large doses of both estrogens and progesterone has been advocated. However, the early institution of adequate diet therapy (reduced salt, high protein, and maintenance calories) will solve many of these problems.

Dr. Lichtenstein: The role of pregnancy in precipitating diseases of the nervous system or altering their course has not been established with certainty. It has been stated, for example, that myasthenia gravis may undergo remission during pregnancy and I have seen this happen, but, in other cases, exacerbations take place. Since the natural history of the disorder is one of variability in the clinical picture, one can never be certain what the pregnancy may do. Multiple sclerosis is a disorder of young adults and, in many instances, the attacks may be quite severe. As with myasthenia gravis, neither the etiology nor specific therapy are known and the question of permitting a pregnancy to occur or allowing it to continue becomes fairly important to all concerned. In instances in which the disorder is quite marked or in which recurrent attacks are frequent, I advise against pregnancy but I have never recommended interruption. I feel that pregnancy has a deleterious effect on the course of multiple sclerosis but, in one case in which I insisted against pregnancy, the patient did very well and had no exacerbations for years afterwards. I have seen many cases, however, in which rather severe attacks occurred within a month after delivery.

Postpartum psychosis is not infrequent but I feel that the development of this disorder is related more to the emotional life of the individual than to the pregnancy. The pregnancy acts as a stress factor rather than as a specific etiology per se. Pressure of the gravid uterus on the pelvic nerves may produce sciatica but this generally responds to conservative therapy. Pregnancy has no direct effect on the course of Huntington's chorea but the hereditary features of this disease are such that I recommend interruption and sterilization. At the present time, I have under observation a patient who is pregnant and has an advanced form of Wilson's disease or hepatolenticular degeneration but I have been unable to note any specific effect of the pregnancy on the disease. I have never seen an instance of chorea gravidarum, but it has been described and I understand it to be a manifestation of toxemia. Epilepsy is a common disorder and pregnancy does not affect it one way or another.

Many gravid women complain of paresthesias in the hands and feet but this is more annoying than serious and is probably related to the associated edema. On the whole, pregnancy is a physiological process which adds to the total

stress picture. In itself, it plays only a minor role in precipitating or altering the course of neuropsychiatric disorders.

Dr. Paul: First, I should like to comment upon certain of the physiologic changes seen at the time of pregnancy which are important in patients with cardiovascular disease. It has long been known that the normal pregnant female develops an increase in total blood volume, an increase in cardiac output, a larger stroke volume, and an increase in pulse rate. The increase in blood volume is chiefly in the plasma fraction and may reach a peak of approximately 1800 cc. This point of maximal load is reached not at the time of delivery but two months before that; thereafter, definite reduction in work of the heart and in total blood volume towards normal occurs until the time of delivery. A slight shortening of the circulation time is also seen but the peripheral resistance is not altered significantly.

It should be pointed out that such patients normally may have signs and symptoms which may suggest heart failure. For example, they may be somewhat dyspneic on effort, slight to moderate ankle edema may occur, and the physician may find the left heart border out towards the axilla as the heart is displaced upward by the elevated diaphragm. Functional murmurs are also found. None of these findings justify the diagnosis of congestive heart failure.

The problems that do exist are chiefly in patients with rheumatic heart disease, notably those with mitral stenosis. Mitral regurgitation is much less of a problem and aortic valve disease is relatively uncommon in women of the child-bearing age. It is true that most women with mitral stenosis can go through pregnancy without difficulty. Those who do poorly tend to fall in the older age group (above 35), or may give a history of congestive failure, or show auricular fibrillation. Hamilton has stressed that any one, or a combination of these factors, may be unfavorable. Should such a patient become pregnant, interruption of pregnancy should be seriously considered if the third month has not been reached. Beyond that time, it is in most cases wise to see if the patient cannot be carried through to delivery with a regime of marked restriction of activity, a low sodium diet, and, if necessary, use of digitalis and diuretics.

Subacute bacterial endocarditis should be mentioned as a possible complication of the portpartum period. Coronary heart disease and congenital heart disease seldom present problems because few patients in these categories become pregnant. It may be mentioned, however, that the simple septal defects may go through pregnancy uneventfully as may patients with more complicated lesions who have received the benefit of surgery. Finally, it should be noted that the woman with hypertension who becomes pregnant runs a definite risk of aggravation of her hypertensive state as a result of the pregnancy.

DISCUSSION

Dr. Harry F. Dowling, Professor of Medicine: Previous history and complications in my experience have been the best criteria of how well a patient will go through pregnancy. If they have faced difficulties well previous to the pregnancy, they will usually have the reserve to do well during the pregnancy. It must be gratifying to Dr. Falls to know that we can now-a-days control two of the major causes of concern, pneumococcal and streptococcal infections, rather well with early and vigorous antibiotic treatment. Two questions, I believe, remain to be solved in this particular area: (1) whether streptococci penetrate the placenta, and (2) whether streptomycin causes eighth nerve damage to the fetus if it is used to treat the pregnant mother for tuberculosis.

Dr. Falls: I agree with Dr. Dowling on the importance of the patient's reserve. My definition of pregnancy is that pregnancy is an internal physiological glandular dystrophy. We could not have a pregnant woman with normal endocrine glands because the hypophysis, pancreas, thyroid, and I believe, the adrenals, are involved in the response of the body to pregnancy. Some women run a tachycardia as a normal reaction and with minimal activity during pregnancy, and I have wondered whether this could be signs of hyperthyroid function which declines postpartum. Many answers will come, we hope, with the study of the endocrine changes with relation to normal physiological changes during pregnancy. Dr. Dowling's question cannot be answered at this time. Much more research remains to be done about the barrier function of the placenta. The placenta is the most wonderful tissue in the world. It functions as the complete digestive system in the fetus, performing

its duties of respiration, internal glandular secretion, and waste removal. Eclamptogenic toxemia may be related to vascular accidents in the placenta resulting in devitalized areas of the placenta causing a leak of toxic products into the maternal blood. The failure of the placenta to detoxify these end products of metabolism before transmitting them to the mother may be related to toxemia. A fulminating toxemia may result from a large vascular defect in the placenta; numerous small lesions may explain the more gradually developing picture.

Dr. Armstrong: It has been an old investigative problem to demonstrate "toxic" substances in disease and identify specific protein fractions and enzyme systems involved. It would be of interest if this could be done in toxemia of pregnancy. Do you find large infarcts in placentas of patients with toxemia?

Dr. Falls: The damaged placenta may frequently present difficulties in finding the infarct because the placenta is expelled too soon after the development of the infarct. Bartholomew, however, has felt that he could differentiate toxemia placentas from normal placentas. He recently was able to diagnose from a large group of placentas presented to him the placentas from patients who were toxemic. One ought to mention that while sciatic neuritis in pregnancy is often due to a sacral nerve root neuritis, secondary to the action of relaxin (causing relaxation of the sacroiliac joints), many pregnant women have neuritis due to toxic end products of the fetus. Chorea gravidarum does occur. We have had a patient in the hospital recently who responded beautifully to immediate caesarian section, despite the fact that she was in an almost terminal state from decompensated mitral stenosis and regurgitation. Fortunately, both mother and fetus survived.

PREVENTION OF CORONARY THROMBOSIS

The prevention of the pathology of coronary artery disease has proven to be of little value. Recent studies of Gofman and his associates indicate a disturbance in the lipoprotein pattern of the molecules of the Sf 10-20 class in atherosclerotic heart disease. The increase in the number of these molecules is associated with an increased rate of development of atherosclerosis. They are present in increased numbers in the postcoronary thrombotic state, also in diseases in which athersclerosis is a frequent complication such as diabetes mellitus, the nephrotic syndrome, hypothyroidism and xanthomatosis. The occurrence of these molecules may be altered by reducing the fat and cholesterol in the diet which, in turn, in the opinion of these authors, reduces the frequency of occurrence of coronary atherosclerosis. *Alphonse McMahon, M.D. The Coronary Problem. West Virginia M. J. January, 1953.*

Indeterminate Pulmonary Lesions

William E. Adams, M.D.
Chicago

Indeterminate pulmonary lesions from a clinical standpoint are those which resist identification when all means of investigation are utilized. They may be neoplastic, inflammatory or congenital in origin.[1] Clinical significance of these lesions is readily appreciated with the realization that a significant percentage are found to be primary lung carcinomas. Between 15,000 and 20,000 deaths occuring yearly in the United States are due to primary Carcinoma of the lung. Thirty to forty percent of these begin as indeterminate pulmonary lesions. Inflammatory conditions such as certain forms of tuberculosis and non-tuberculous pneumonitis may remain unrecognizable. On the basis of their clinical manifestation as well as on x-ray examination, at times these pathologic states may appear not unlike malignant lesions. A third group of patients, present congenital lesions of either the pulmonary or vascular types. This group is the smaller of the three; however, these patients present just as great a problem in identification.

CLINICAL MANIFESTATIONS

The syptomatology of indeterminate pulmonary lesions may vary considerably. Symptoms are not infrequently entirely lacking; however in other cases one or more of a large variety of complaints more or less common for pulmonary lesions in general may be present. These include cough with or without expectoration, pain, hemoptysis, malaise, anorexia, weakness and loss of weight. In the case of tumors, the first symptoms may be produced by invasion of the pleura or by distal metastases. Sometimes necrosis of the tumor with sypmtoms of pulmonary suppuration is the first evidence of its presence. Although the occurence of some of these ailments may be strongly suggestive of the presence of particular lesions especially in certain age groups, this information is insufficient on which to base a plan of management. Fortunately, for these patients, thoracic surgery has reached the stage of development predicted by Adler[2] in 1912 when he wrote, "There is every reason to hope that the technique of this new branch of surgery (chest) will be still further developed and that in the near future thoracotomy and operations on the lung will be attended by no more risk than peritoneal operations today. . . . When all the means of diagnosis (outlined in this little study) fail, where there are suspicions of tumor but no assurance is possible, there should be — it is emphatically here stated — as little hesitation in resorting to an exploratory thoracotomy as there is now in submitting to an exploratory laparotomy." When Adler's advice is accepted the prognosis for this group of patients is quite favorable.

Presented before the Section on Pathology, 11th Annual Meeting Illinois State Medical Society, Chicago, May 23, 1951.

From the Department of Surgery of the University of Chicago.

PATHOLOGICAL CONSIDERATIONS

What is the histological nature of these lesions and what are some of their pathological characteristics.

Neoplasms. Most primary neoplastic lesions of the lung are of the malignant type, only a small percentage being benign in nature. These latter include hamartoma, neurofibroma, liponia and some adenomata. Of the malignant group, a larger percentage of the peripheral lung tumors are of the squamous cell type than was formerly suspected. Some of these are very slow growing, a few having been followed by repeated x-ray examination for many months or as long as three or more years. Metastases may still be absent at the end of that period. The following case is a good illustration.

Case 1. A 45 year old white male was referred to the Chest Clinic because of a pulmonary lesion found on routine x-ray examination when the patient was applying for a job. He was entirely asymptomatic and the physical findings were normal. An x-ray of his chest showed a circumscribed opacity in the right lower lobe with a suggestion of beginning excavation. (Figure 1) Repeated sputum examinations were negative for acid-fast organisms including gastric lavage and guinea pig inoculations. The possibility of a neoplasm was strongly considered. Bronchoscopic and other examinations were entirely negative. The patient was explored and a tumor of the lower lobe was found.

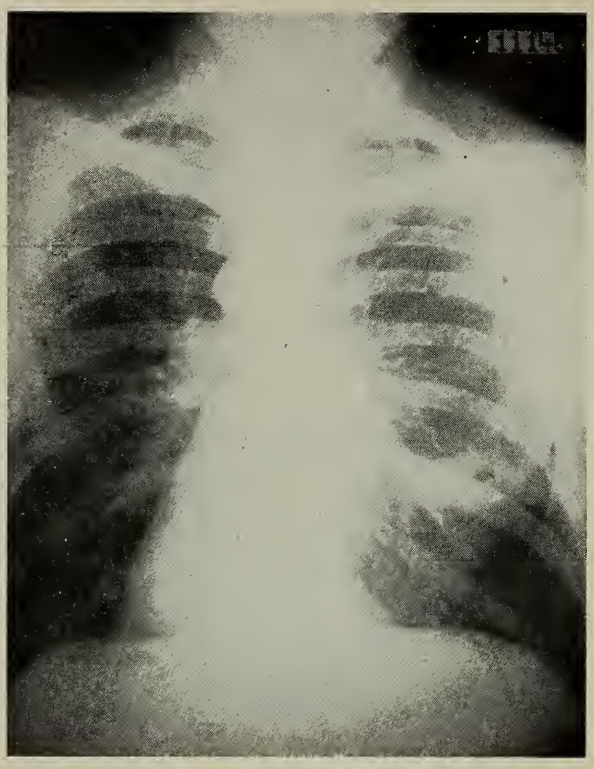


Figure 1. (Case 1) X-ray appearance of a peripherally located squamous cell carcinoma of the lung. Note cavity within opaque area.

Microscopic sections proved this to be a squamous cell carcinoma, the central portion of the tumor having become necrotic, thus explaining the cavitary appearance on x-ray examination.

Adenocarcinoma of the lung, however, metastases earlier; symptoms due to the metastases are not infrequently the first caused by the tumor. The two cell types have been found co-existing in the same tumor in a number of surgical specimens. Undifferentiated cell lesions are more rapidly growing and usually do not fall into the group of indeterminate Pulmonary lesions.

Inflammations. Circumscribed tuberculous lesions are not infrequently impossible to identify. The majority of these are tuberculomas.

In addition, encapsulated tuberculous cavities containing inspissated purulent material are occasionally seen and appear on x-ray examination not unlike a neoplastic lesion. Although tubercle bacilli may not be found in the exudate or the wall of the cavity, cultures and guinea pig innoculation from the surgical specimen will usually prove the identity of the infection. This is well illustrated by the following case:

Case 2. This sixty-two year old white female came to the surgery clinic complaining of a non-productive cough for from ten to fifteen years. She had had no other symptoms until six months previously when she began to have spells of weakness and dyspnea on exertion. Her doctor took a chest film and found a "lung tumor."

Physical examination revealed a well developed, very well nourished female who did not appear ill. There were no significant findings in the chest, and the remainder of the examination was normal except for a blood pressure reading of 186/80. The patient had a normal temperature, white blood count of 9,800, and the sputum was negative for acid-fast bacilli. A roentgenogram of the chest showed a sharply defined, rounded shadow, 6 cm. in diameter, in the right upper lobe thought to be a primary carcinoma of the lung. Bronchoscopy and other tests revealed no abnormal findings.

At exploration, the right upper and middle lobes were found firmly attached to one another by a hard mass in the upper lobe. They were therefore both removed. The patient made an uneventful recovery. On section the lesion was found to be fibrocaseous tuberculosis with no bronchial communication. The sputum has remained negative and the patient has been well, without other evidence of tuberculosis.

The final diagnosis was fibrocaseous pulmonary tuberculosis of the right upper lobe with complete absence of bronchial communication.

Occasionally, circumscribed, non-suppurative infiltrative tuberculosis does not give rise to a positive sputum and produces a clinical picture suggestive of malignancy. The true nature of the pathology may need to await histological sections of the surgical specimen.

Chronic non-tuberculous suppurative pneumonitis, an uncommon clinical entity, usually presents a chronic course of low grade infection without specific means by which it may be identified. Again its differentiation from pulmonary malignancy or tuberculosis may be impossible without histological examination of the tissues removed.

Congenital lesions. These may be of the pulmonary or vascular type. In the former the pathology may consist of (1) one or more obstructed cysts filled with fluid or air, (2) abnormal development of the lung with many minute cysts, or (3) a stage of development of the lung prior to the formation of alveoli. Infection of the involved part with the production of cough, expectoration and a septic course usually calls first attention to the anomali. The following case is an example of Group 2 and 3:

Case 3. An 8 year old white boy was first seen complaining of a productive cough with intermittent hemoptysis and fever for approximately one year's duration. The patient gave a history of bilateral pneumonia with surgical drainage of bilateral empyema during the earlier part of this period. On examination he appeared chronically ill and was somewhat dyspneic. The entire left lung was dull to flat, and breath sounds were either absent or bronchial in character. The right lung appeared normal. Laboratory findings included hemoglobin, 10 gm.; red blood count, 3.9 million; and white blood count, 14,000. X-rays showed the left lung to be entirely airless with a slight deviation of the heart shadow toward the right side (Figure 2a). Following the injection of iodized oil, only the primary bronchi of the upper and lower lobes were outlined. On bronchoscopic examination a moderate amount of foul pus exuded from the left main stem bronchus and an especially large amount from the left lower lobe. The right side was clear. The differential diagnosis included massive empyema, chronic suppurative pneumonitis with abscess formation, and possibly bronchiectasis. Pneumonitis, however, was thought to be the most likely cause of his trouble. A thoracentesis revealed no evidence of pus in the pleural cavity. Therefore, after preparation of the patient for operation by several transfusions aggregating a total of 900 cc. of whole blood and by postural and bronchoscopic drainage as well as chemotherapy, an exploration was made. The left upper lobe was found to be completely atelectatic but not infiltrated. It was airless, but no large cystic spaces could be identified. The lower lobe was removed by the dissection technic, and although the upper lobe could not be re-expanded, it was left in place.

Following operation the patient made an uneventful recovery. However, the upper lobe remained completely atelectatic for a period of approximately four to six weeks then become inflated spontaneously (Figure 2b).

On cut section the surgical specimen revealed several small cavities filled with frank pus. The remainder of the tissue consisted of markedly fibrosed and consolidated lung. On microscopic examination the walls of the spaces were lined by columnar ciliated or stratified squamous epithelium, and various elements of the bronchial wall were present. In the remainder of the lung, abnormal development of the various lung elements were present such as numerous small spaces lined by cuboidal epithelium and a lack of normally developed terminal respiratory units. The degree of infection was not as great as suspected from gross examination of the tissue.

In patients with a pathologic process such as the above described, it is frequently impossible to differentiate between a chronic pneumonitis and other pathologic lesions. A history of an insidious onset of a pulmonary suppurative process in a child without the usual etiologic factor for the production of bronchiectasis or lung abscess should strongly suggest the possibility of congenital malformation of the lung. Bronchoscopic examination and x-rays following iodized oil injection are usually not diagnostic. In such cases when the patient's condition warrants it and a thorough preparation for operation has been made, exploration and resection of the involved portion is indicated.

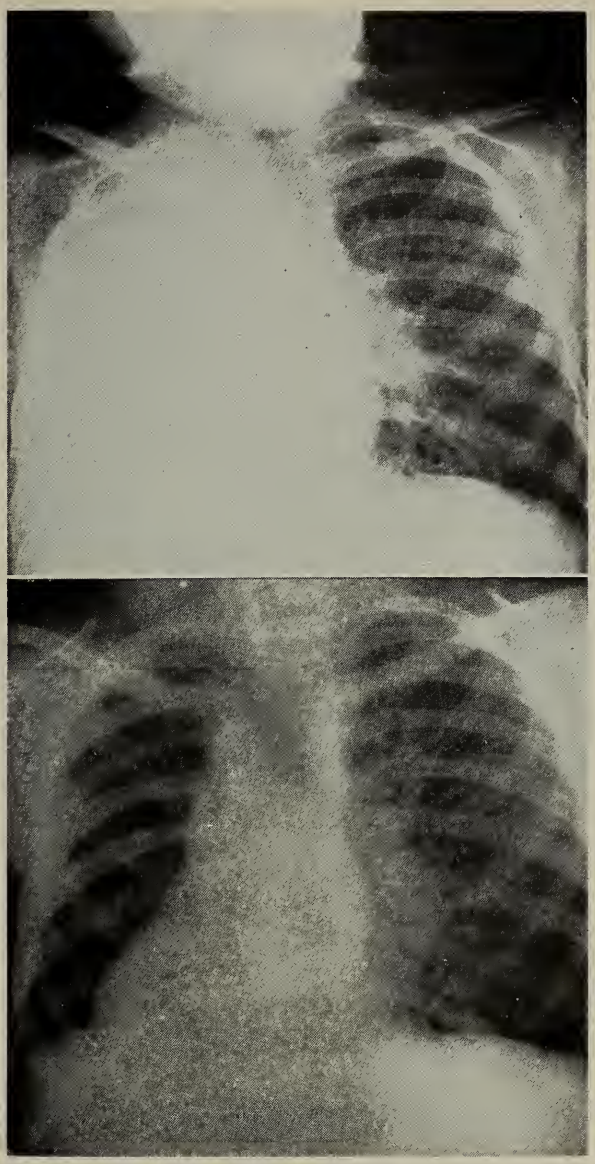


Figure 2a and b. (Case III) X-ray appearance before and after resection of the left lower lobe in an 8 year old boy for congenital malformation of the lung. The left upper lobe is now fully inflated (b).

Vascular malformations within the lung produce symptoms less frequently than pulmonary anomali. When an arteriovenous fistual of a sufficient size to produce alterations in the blood picture develops, the condition is usually recognized. However, if the blood picture is

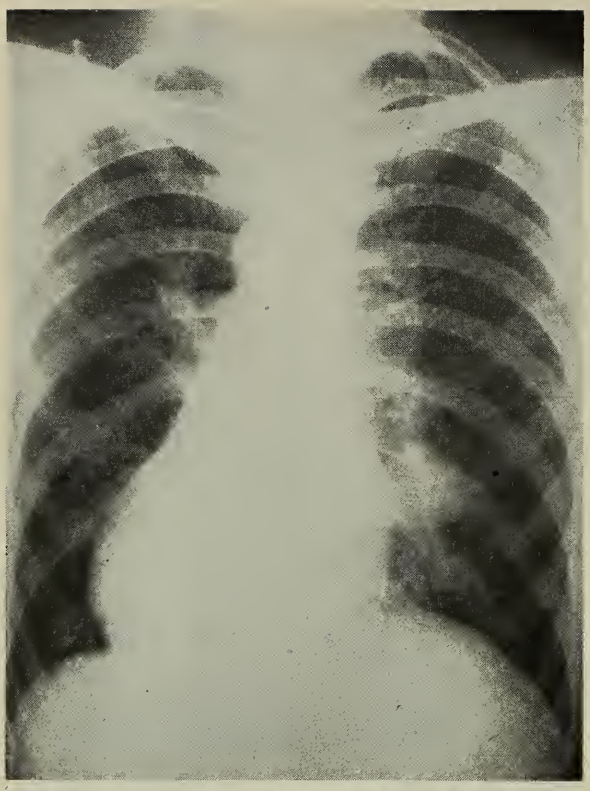


Figure 3. (Case IV) X-ray appearance of circumscribed lesion produced by a vascular malformation of the lung.

normal, the only symptom is an occasional hemoptysis and the finding of a "spot" seen on x-ray examination. There may be no pulsation on fluoroscopic examination and the lesion thus remains unidentified. The following case report is illustrative of these characteristics:

Case 4. A 28 year old white male, complained of several small hemoptyses during the previous six months. He had been told by a physician that he had heart trouble. Otherwise, he had been in good health. Physical examination revealed only normal findings. An x-ray of the chest showed a circumscribed, circular opacity in the lower right lung field (Figure 3). It did not pulsate on fluoroscopy. X-rays taken at another institution two years previously showed no evidence of the lesion. The results of diagnostic tests failed to identify the lesion. Differential diagnosis included a cyst or tumor of the lung or mediastinum or possibly a tuberculoma. Because of the fact that x-rays of the chest taken two years previously were normal, and because of the repeated hemoptyses, exploration was recommended. At operation a spherical shaped mass was found in the right lower lobe. On compression this mass was found to pulsate, thus indicating an aneurysm. The right lower lobe was removed. A large microscopic section through the lesion showed it to be an aneurysm with a small arterial and venous communication. Most of the aneurysm was obliterated by an organizing thrombus. The final diagnosis was congenital malformation of the lung.

Other conditions which produce shadows on x-ray examination and which may resist recognition, include interlobar fluid cysts, mediastinal coelomic and bronchial cysts and other mediastinal tumors. Although their position within the thorax at times may be highly suggestive of their nature, a positive diagnosis frequently must await surgical exploration. Although much progress has been made in the operative care of intrapulmonary lesions, only 9 percent of all patients seen with primary lung cancer are living at the end of five years. This is largely due to a delay in early recognition. If the benefit of early exploration in patients with indeterminate pulmonary lesions is kept in mind, the outlook for pulmonary malignancy will be much enhanced.

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What the New Doctors' Draft Law Means to You

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The purpose of this article is to inform the physicians in Illinois on the changes in the Doctors' Draft Law - Public Law 84 - 83 Congress, and of current policies of the State Medical Advisory Committee to the Selective Service System and the Department of Defense.

In the last Advisory Committee article, which was printed in the September 1952 issue of the Illinois Medical Journal, we tried to explain the double liability of service for some registrants, the latest policy with regard to the essentiality of residents, teachers, etc., and which physicians Selective Service and the Armed Forces were calling into service.

We believe it wise to first point out the changes in the regulations and law which deal with Special Registrants under the Doctors' Draft Law. To best define the four priorities, we have copied the recent State Memorandum of Illinois State Headquarters Selective Service System No. 16-7, which reads as follows:

"Subject: *Changes in Priorities - Special Registration No. 1*

The Four Priorities

1. Following are the priorities of special registrants as established by Public Law 84, 83d Congress, which amended the Universal Military Training and Service Act as of 29 June 1953:

Priority I

Those persons who participated as students in the Army Specialized Training Program or similar programs administered by the Navy, and those persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in medical, dental or allied specialist categories, who have had less than 90 days of active duty in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, the Public Health Service, or other service as defined in paragraph 2 below (exclusive of the time spent in postgraduate training).

Priority II

Those persons who participated as students in the Army Specialized Training Program or similar programs administered by the Navy, and those persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in one of the categories referred to above, who have had 90 days or more but less than 17 months of active duty in the Army, Air Force, the Navy, the Marine Corps, the Coast Guard, the Public Health Service, or other service as defined in paragraph 2 below (exclusive of the time spent in postgraduate training).

Priority III

Those not included in the first and second priority who did not have active service in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard or the Public Health Service subsequent to September 16, 1940, or any active service as defined in paragraph 2 below.

Priority IV

Those not included in the first and second priority who have had one day or more of active service in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard or the Public Health Service subsequent to September 16, 1940, or any active service as defined in paragraph 2 below.

(Priority IV includes persons with ASTP or V-12 service or corresponding deferment who have had 17 months or more of active duty but less than 21 months. It also includes *all* persons who have had 21 months or more of active duty and who therefore are not liable for service under Public Law 84, 83d Congress.)

Active Duty Defined

2. Active duty as defined in the new Law includes active service in the Armed Forces of the United States or the Public Health Service subsequent to 16 September 1940, service as a conscientious objector under the 1940 Selective Service Act or under the current Act, active service with cobelligerent countries after the date of alliance and prior to 2 September 1945 (See

Operations Bulletin No. 98), and under certain conditions employment by the Panama Canal Health Department between 16 September 1940 and 2 September 1945.

Duty Not Considered as Active Duty

3. *Not* considered as active duty are the following:

a. Periods in ASTP, V-12, or similar programs of the armed forces.

b. Periods of internship, residency or other post-graduate training.

c. Periods of active duty for training only subsequent to 29 June 1953.

d. Periods of active duty for the purpose of physical examination only.

e. Periods of active duty in the Public Health Service terminated after 30 April 1953 without the consent of that agency.

4. All active duty as defined in paragraph 2 above, except that which is specifically excluded in paragraph 3 above, will be considered in determining a special registrant's priority, regardless of whether the active duty was performed prior to or subsequent to the period of ASTP, V-12 or deferment.

5. For a special registrant to be placed in Priority I or Priority II, his ASTP or V-12 program or deferment must have been in a premedical, medical, predental, dental, veterinary or allied specialty. Registrants who were students in other types of ASTP or V-12 programs, or who had educational deferments for the purpose of pursuing some course not related to the healing arts, will not be placed in Priority I or Priority II. For example, a special registrant who was a student in an ASTP course in engineering, with one day or more of active service, belongs in Priority IV, not Priority I or II."

PAUL G. ARMSTRONG
State Director

The new law states that except in time of war or National emergency hereafter declared by the Congress, no person who has served in the active service since 16 September 1940 for a period of twenty-one months or more, shall be liable for induction or reinduction under this law.

The next point that has been changed is that no person liable for induction under this law shall be held to be ineligible for appointment as a commissioned officer of an Armed Force of the United States on the sole ground he is not a citizen of the United States and has not made a declaration of intent to become a citizen thereof; provided any such person who is not a citizen of the United States who is appointed as a commissioned officer may in lieu of the oath prescribed by Section 1757 of the revised statutes as amended take such oath of service and obedience as the Secretary of Defense may prescribe.

The National Advisory Committee has been defined more fully in that the law now reads:

"It shall be the duty of the National Advisory Committee in conjunction with the State and local volunteer advisory committees to make determinations with respect to persons in residency training programs who shall be recommended for deferment for the purpose of completing such residency programs, and in making such determinations shall give appropriate consideration to the respective needs of the Armed Forces and the civilian population. The National Committee Advisory in conjunction with the State and local volunteer advisory committees are further authorized to make appropriate recommendations with respect to members of the faculties of medical, dental, veterinary, and allied specialist schools, schools of public health, and with respect to physicians, dentists and veterinarians engaged in essential laboratory and clinical research, having due regard to the respective needs of the Armed Forces and the civilian population."

Section 4 of the law deals with any member of a Reserve component who is or shall be ordered to active duty on or before 1 July 1955 as a physician, dentist or allied specialist, and who shall, under regulations prescribed by the President, be appointed, reappointed or promoted to such grade or rank as may be commensurate with his professional education, experience or ability.

The periods of active duty which must be served by persons called into service shall not exceed (a) twenty-four months if he has had less than nine months' active service in paragraph 4 (a) of the Universal Military Training and Service Act as amended, (b) twenty-one months if he has had at least nine months' service but less than twelve months of such

service, (c) eighteen months if he has had at least twelve months' but less than fifteen months' service, (d) fifteen months if he has had at least fifteen or more months of service since September 16, 1940, but prior to the date of his order to active duty.

This is a general description of the new law. We have not included the provision that has been made for considering the service of persons who served with our allies or cobelligerents, which will be discussed in a later issue.

In order that we might bring you up-to-date on what has happened in the last few months, it might be well to point out that Selective Service has called the majority of priority I and priority II registrants. There are a few who are awaiting call in that they have just become available for service.

So far as priority III physicians are concerned, Selective Service is calling only those who were born after 30 August 1922 at this writing. The Advisory Committee as a whole is not reviewing the cases of those individuals born before 1 January 1919. The cases of physicians born before 1 January 1919 will be reviewed at such time as the temporary age restriction is dropped by National Selective Service.

The latest call for Special Registrants from Illinois, Call No. 16, is for twenty-seven physicians who are ordered for induction on 27 August 1953. These men will be offered commissions in the Medical Corps of the Army and if commissions are accepted will then be called to active duty approximately thirty days later. Those not accepting commissions will have to report for induction as ordered.

Prior to the graduation of the medical school students this year, the seniors were given information by the Advisory Committee with regard to their liability for service. A majority of students filled out questionnaires for the Advisory Committee, which gave us some excellent statistics. It is interesting to note that of the 337 who registered with the Advisory Committee 207 were veterans who belong in the priority IV group and 130 were in the priority III group. Of the individuals in priority IV, the following is a breakdown of their service:

Months of service	Number registered	
Under 3 months	1	
3 months or more, but less than 6 months	1	
6 months or more, but less than 9 months	3	
9 months or more, but less than 12 months	10	
12 months or more, but less than 15 months	25	
15 months or more, but less than 18 months	24	
18 months or more, but less than 21 months	30	
21 months or more, but less than 24 months	27	
24 months or more, but less than 3 years	66	
	187	Total
Over three years up to and including 50 months	20	207

Of the individuals in priority III, the following is a breakdown of their ages:

Born in	Number	
1923	1	
1924	1	
1925	1	
1926	1	
1927	13	
1928	83	
1929	28	
1930	2	Total
	130	130

We have informed our Local Advisory Committee Members that when reviewing the cases of individuals in private practice in small communities, they must consider if an individual can be spared without endangering the general health of the community. The Local and State Committees must consider the availability of other physicians within a reasonable travel distance who can render necessary medical service. A replacement must be sought when an individual has been declared essential. When seeking a replacement, the physician concerned must contact the Secretary of the Illinois State Med-

ical Society and request that a replacement be obtained for him. It is necessary that an earnest effort be made by the individual concerned to find such replacement.

The policy with regard to resident physicians has greatly changed in the last two months. We are no longer permitted to recommend the essentiality of a priority III physician who was born after 1 January 1920, if he is engaged in a residency training program, or is to begin a residency training program if he is eligible for service as either a regular or Special Registrant. Those eligible only as Special Registrants should not be accepted or assigned to residencies unless the hospital employing the resident can show it cannot operate without the services of that resident. When a hospital does request a recommendation as to the essentiality of a resident, it must show that his being a member of their house staff is necessary to the National health, safety or interest; that his services cannot be performed by another physician and there is no other physician to replace him. If a hospital desires to employ a resident to serve their institution temporarily until such time as the resident would be called, there is no objection, provided it is understood he will not be delayed beyond the time he is called to service.

The policy in requesting essentiality for interns for a one year internship still remains. We have already sent essential recommendations to local boards on the interns who started training on 1 July 1953.

The review of the cases of older men in priority III indicates that the teaching and research fields are getting to be a greater problem. The cases of these physicians must be carefully reviewed to make sure no other individual is available to teach or do the research for the institution concerned. The majority of part time teachers should be replaced with full time teachers.

The policies we have tried to explain are in accordance with those of the National Advisory Committee and I hope I have given you sufficient information, but if there is further data you desire, please feel free to contact me.

LEAD ABSORPTION

Many cases of excessive lead absorption do not originate from occupational exposure. It is entirely possible, for instance, for an individual to absorb a toxic amount of lead by continually drinking water transported from the main in the street to the tap in the house through lead pipes. Lead piping within dwellings is found only in very old houses. There are a number of lesser sources of lead intake to the body in normal everyday life, as evidenced by the presence of lead in the urine in concentrations ranging from 0.01 to 0.01 mg. of lead per liter of urine. Lead is also a normal constituent of blood, being present in concentrations ranging from 0.01 to 0.05 mg. of blood. *William L. Lea, Ph.D. The Diagnosis Of Illness Due To Excessive Lead Absorption. Wisconsin M.J. May 1953.*

CASE REPORTS



Unusual Acute Abdomens

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The fact that appendicitis can simulate other abdominal conditions is well known, and vice versa[5]. The following two cases present unusual conditions at the time of surgery.

E. K., 27 year old white male came to the emergency admittance desk at Swedish Covenant Hospital on the morning of February 4, 1952 because of abdominal pain which had started in the epigastrium. He did not complain of either nausea or vomiting. The patient was sent home after examination because findings did not warrant an exploratory laparotomy. His urine was negative; WBC was 10,500, and rectal temperature was 99.6 degrees. He was told to report later during the day.

The patient had pain radiating to the R.L.Q. during the day. It was getting worse and he came back to the hospital at 10:15 P.M. on February 4, 1952, 14 hours after the onset of pain. Physical examination was negative at that time except for tenderness in the R.L.Q. which was rebound in character. No masses were palpated. The WBC was 16,100, polys. 96, lymphs. 4, hb. 13 gms., RBC 4,390,000. Rectal temperature — 100.2 degrees.

A diagnosis of appendicitis was made and laparotomy performed. A small amount of fluid was present on opening the peritoneal cavity. The appendix and lower ileum were normal but on the cecum was an infarction of one of the appendices epiploicae, which was adherent to the serosa. The pathological diagnosis was: hemorrhage into fat and vermiform appendix.

C.R., 53 year old white male, was admitted to Swedish Covenant Hospital at 1:30 P.M. on January 28, 1952, because of abdominal pain. He had awakened at 5:00 a.m. with sharp pain in the R.L.Q. which lasted 15 to 20 minutes, followed by attacks of pain which occurred about every 15 to 20 minutes at first. Later they became more severe and continuous. He had neither nausea nor vomiting and had not experienced a similar attack previously.

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Physical examination revealed moderate obesity; the patient was 5 ft. 6 in. in height and weighed 192 pounds. There was tenderness over the right side, lower quadrant unaccompanied by rigidity. No masses could be palpated.

The RBC was 4,500,000; WBC, 11,400, hb. 13 gms., polys, 68, lymphs. 32. Urinalysis negative. Rectal temperature — 99.8 degrees.

A diagnosis of appendicitis was made and a right rectus incision was performed. The terminal ileum came into view with two fish bones protruding .5 cm. and about 3mm. apart. The bones were pulled through the bowel, then interrupted Lembert sutures closed the defect. Appendectomy was performed. Harris tube was inserted later. The pathological diagnosis was: fish bones and chronic fibrous appendix.

After surgery, it was found that the patient had eaten fish on Friday. Surgery was on Monday.

These two cases had localized pain and tenderness in the abdomen, not preceded by nausea or vomiting but there was epigastric pain in the case with appendices epiploicae infarct. In appendicitis nausea, vomiting, and epigastric pain usually are present. The temperature did not rise in the man with perforated bowel and the leukocytes were not increased greatly; but in the appendices epiploicae ease both temperature and leukocytes rose. Fish bones perforating the bowel and infarction of appendices epiploicae may cause acute abdominal symptoms. The appendices in both cases were not abnormal.

To establish a diagnosis of appendices epiploicae it is not necessary to explore the entire colon because the findings — local pain, tenderness and muscle spasm — usually are present over the lesion at its location. The appendices, as a rule, are arranged in two rows. Occasionally there may be one row or three rows. The number in adults is approximately 100. The appendices are small pedunculations or pouches of fat extending from cecum to rectum[1].

A survey of the literature does not indicate that serious complications are frequent and it is probably that conservative treatment without operation probably would be adequate in most cases if the diagnosis (appendices epiploicae) could be established clinically[2]. Pines[7] thinks epiploicae appendices act as fat pockets protecting the redundant intestinal vessels from occlusion during bowel distention. Babcock[9] states that symptoms of a foreign body in the intestine are digestive, obstructive, ulcerative, or perforative, and treatment is operative or Vienna treatment. Rentschler[10] reports a pin perforation of the appendix of a 17 year old girl.

SUMMARY

1. Fish bone perforation of ileum is a clinical entity, as in infarction of appendices epiploicae.

2. Fish bone perforation usually gives the same symptoms as any other type, if not sealed or leakage prevented.

3. Epigastric pain was present, as in appendices epiploicae infarction, but no nausea or vomiting.

4. There was no palpable mass in either case.

5. Preoperative diagnosis was difficult.

6. Any case with localized tenderness (but not necessarily pain) warrants an exploratory laparotomy.

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EDITORIALS

BCG VACCINE

The value of BCG vaccine in the prevention of tuberculosis is still controversial. It has been used on 50 million persons of various ages, living in different parts of the world; and on those living in mansions, slums, and jungle huts. According to Aronson and Aronson[1] "The diversity of opinion has been due in great part to the lack of adequately controlled investigations and to the difficulty of dissociating the protective role of BCG vaccine from an almost universal decrease in the morbidity and mortality from tuberculosis, antedating the use of BCG vaccine."

Medicine has many problems but usually solves them within a reasonable length of time. BCG, first used in France in 1921, is an exception. Many physicians are beginning to weary of the controversy and have become somewhat leery of the authorities who are doing the research. If the investigations are not adequately controlled, why waste more money on similar projects? There is a possibility also that the opponents of the vaccine are hypercritical of the results or the researchers are too timid or conservative in their appraisal of its protective value.

Aronson and Aronson, for example, reported on the joint investigation by the Henry Phipps Institute, University of Pennsylvania, and the Branch of Health, Bureau of Indian affairs, Department of the Interior. The project was a long term investigation. It began in 1935, and the injections of the vaccine and the control solutions were not completed until February, 1938. The investigation was conducted in five geographical areas and included eight Indian tribes living under greatly different climatic conditions. This was an ideal proving ground considering that the mortality rate from tuberculosis on the reservations studied ranged from 200 to 300 per 100,000 while the rate in Alaska ranged from 500 to 600 per 100,000.

The mortality from all causes and from tuberculosis was again determined 15 years after the study was initiated. During this period a total of 71 vaccinated and 128 controls died from all causes. Twelve of the vaccinated died from tuberculosis, a rate of 0.56 per thousand person years of observation. Among the controls, 65 died from tuberculosis, a rate of 3.32 per thousand person years. Among the 65 unvaccinated controls, 32 died from pulmonary tuberculosis, 2 from bone and joint tuberculosis, and 31 from acute miliary or similar forms of tuberculosis including tubercular peritonitis. The tubercu-

1. Aronson, Joseph D. and Aronson, Charlotte F. Appraisal Of Protective Value of BCG Vaccine. J.A.M.A. 149:334 (May 24) 1952.

lin reactions of controls dying from acute forms of the disease were, for the most part, negative within the year of death or had become positive for the first time within that period. According to the authors the data "support the concept that there is a close but not absolute relationship between resistance to reinfection and hypersensitivity."

THE PHYSICIAN PLACEMENT SERVICE

An increased interest in the Placement Service of the Illinois State Medical Society has been noted in the Secretary's office since the role of the A. M. A. in the over-all program of the state societies has been given consideration by its House of Delegates. All inquiries from physicians concerning desirable locations in Illinois received in the A. M. A. office are referred immediately to our Placement Service, with the result that our mailing list has been increased considerably.

During the past two summers the Council on Medical Service of the A. M. A. has employed an outstanding medical student to visit several state medical society offices, for the purpose of evaluating their placement programs. The offices of several state societies that have conducted Placement Services for some time have already been visited, and the student employed at the present time is visiting several offices which are now initiating this service. This is a most worthwhile project; both the services of the state societies and the A. M. A. are being benefited by this exchange of ideas.

Several farm journals and other publications have recently carried articles concerning the advantages of rural practice, and reference has been made to the Placement Services conducted by several state medical societies.

The role of the county medical societies in bringing about a more equitable distribution of physicians cannot be overemphasized. It is the responsibility of the county societies to cooperate in every possible way with community groups within their counties that are making serious efforts to find capable physicians for their communities. Such efforts on the part of communities should be reported to the Placement Service of the state society, which is in a position to give concrete suggestions to the committees which have been delegated the responsibility of encouraging physicians to open offices in their communities. Actually the county medical society is in the best position to properly evaluate the needs of communities within their counties.

It is the policy of the Placement Service of our Society to secure a verification of the reported need for a physician in a certain community from the county society before making an effort to secure a physician for this community. Some of the blanks used in reporting the information needed seem to indicate that little thought has been given to the matter. Whenever possible it would be advisable for the Secretary to secure the opinions of several members of his society, especially those who practice in the community reported as being in need of physicians, before returning the completed blank.

The Placement Service sends out weekly bulletins to the mailing list of physicians looking for new locations, concerning the various communities that have been reported, but not until complete data concerning the community has been secured. This data includes such information as the population of the town itself, as well as that of the trade area, the number of physicians in the community and their ages, the hospital facilities available, the availability of office space and living quarters, the possibility of a physician securing financial assistance from the community if necessary, the principal sources of income, the churches, schools, recreational facilities, as well as other details.

No physicians are added to our mailing list to receive these bulletins until complete information concerning their qualifications has been furnished. Many committees sponsoring the movements to secure resident physicians for their communities request data concerning the physicians who have looked over their town. We are in a position to furnish them with information concerning the physician, such as his age, medical training, citizenship status, marital status, religious affiliation, internship, residency, license, specialty training, if any, professional organization memberships, reason for relocating, previous locations, military status, etc.

The Illinois State Medical Society is proud of its record in assisting a good many physicians,

members of our society and others, find desirable locations for the practice of medicine. We feel that our assistance to rural communities is an excellent public relations medium at a relatively low cost to the society.

WILLIS I. LEWIS HONORED BY HOME FOLKS AT DINNER

Willis I. Lewis, M.D., of Herrin, who became president of the Illinois State Medical Society at the conclusion of the annual meeting in May, was the guest of his home town friends May 28 at a dinner given in his honor at the West Frankfort Country Club. Leo J. Brown, M.D., of Herrin, was master of ceremonies. More than one hundred thirty persons attended, mostly physicians of Williamson and nearby counties.

The guests included Arkell M. Vaughn, M.D., and Mrs. Vaughn of Chicago. Dr. Vaughn is president elect of the Illinois State Medical Society and will succeed Dr. Lewis a year hence. Another guest was James S. Templeton, M.D., of Pinckneyville, who is Illinois' outstanding general practitioner for 1953, and Andy Hall, M.D., who was national outstanding general practitioner in 1950, also attended.

The principal speaker was D. W. Morris of Carbondale, president of Southern Illinois University.

The staff of the Herrin Hospital, through Dr. Brown, presented to Dr. Lewis a gavel bearing this inscription: "To Willis I. Lewis, president of the Illinois State Medical Society, with best wishes. Presented by the Herrin Hospital Staff, 1953." Dr. Lewis, in accepting the gavel, pointed out that it was a symbol of authority which could be used rightly or wrongly, and he promised that he would endeavor always to use it rightly.

Dr. Morris spoke on the richness of experience and contact with people that is unique with the medical profession.

"In your hands," he said, "you have the most precious and intimate contact with people. You have an opportunity for joyful recompense far more than most of us. Giving, working, teaching and a sense of friendship for the people epitomize the good physician.

"Dr. Lewis is a man who has grasped the sense of his profession and has left behind admiration and friendship in those with whom he has had contact."

Dr. Lewis, in replying, said it was his greatest pleasure to meet the people he has cared for, and the two thousand or more babies he helped bring into the world.

LOVE AND STATISTICS

Statistics are wonderful. According to a Metropolitan Life Insurance Company release, Americans are now marrying early and the most recent data show that nearly 17 per cent of all girls age 15 to 19 are married or have been married as compared with only 12 per cent in 1940. The proportion jumps to 69 per cent in the 20-24 age group as compared with 53 per cent in 1940.

Since the menfolk enter the picture somewhere along the line, the male trend is somewhat the same. Almost half the men age 20-24 are or have been married as against 28 per cent in 1940. Statisticians predict that early marriage will continue in our country so long as there are favorable economic conditions and our youngsters are allowed to mix socially with relative freedom.

The wartime and postwar marriage boom is not confined to the United States; it is noted also in Ireland, Sweden, and Norway where late marriage long has been common. In France and Germany, the trend is in the opposite direction because a large number of young men were out of the country during the war.

EARL H. BLAIR, M.D., HONORED

Dr. Earl H. Blair, Chicago, Chairman of the Illinois State Medical Society Committee on Military Affairs and Emergency Medical Service, was one of the recipients of the 1953 Freedoms Foundation Civil Defense Awards being given to 65 volunteer Civil Defense workers in 34 States.

Dr. Kenneth D. Wells, President of Freedoms Foundation, said in his announcement of these awards, "Civil Defense is the new, critically important function of the nation's total defense and a responsibility of real citizenship. The nation, in each community in the land, owes its wholehearted respect and everlasting thanks to these selfless Americans who voluntarily expend their efforts in Civil Defense. They are rendering paramount service toward maintaining the American Way of Life".

The three Illinois Awards were made at excer-

cises in the Little Theatre of the Museum of Science and Industry, Chicago, on July 22, 1953, with Brigadier General Robert M. Woodward, Director of Civil Defense, State of Illinois, making the presentation.

ESTHER A. FRASER HONORED

On Sunday, July 12, a garden party was held to honor Mrs. Esther A. Fraser in recognition of her forty years of service to the Chicago Medical Society. Over 600 physicians and their wives gathered at the home of Dr. and Mrs. Walter C. Bornemeier in Niles Township.

In the receiving line, Mrs. Fraser was attended by Past Presidents of the Chicago Medical Society. Cake and coffee were served at tea tables under the trees during the hours from three to five.

As the guests arrived, they were asked to sign a guest book for Mrs. Fraser, and an opportunity was given them to look through the three volumes of letters received from physicians and friends throughout the country.

Mrs. Fraser has well earned the tribute paid her by members of the Chicago Medical Society, the Illinois State Medical Society and the American Medical Association who were present during the afternoon and evening. There are few employees of organized medicine who have given as fully of themselves to their profession or their position as has she. In the forty years Mrs. Fraser has been associated with the Chicago Medical Society she has developed and maintained a charm and a dignity which have assisted her in her ability to deal with people and with situations.

The tribute given her was as sincere as her services, graciously given and graciously received.

Tuberculosis is often at least partially disabling and is subject to remissions and exacerbations. The patient who has recovered from the disease can frequently not risk returning to the work at which he earned his living before he became ill. If he is to return to active life with any assurance that he will not break down again, it may perhaps be necessary for him to learn a new way of living and working. Robert J. Anderson, M.D., Medical Papers of the Annual Meeting of the Canadian TB Assn., May, 1951.

The essential features of the treatment of renal tuberculosis are sanatorium care supplemented by what have been shown at the present time to be the most effective antituberculous drugs. These are streptomycin, PAS and the hydrazine derivatives of isonicotinic acid. None of the chemotherapeutic agents alone, however, can be depended upon to cure or control an established renal focus of tuberculosis. Fletcher H. Colby, M.D., The New England J. of Med., April 16, 1953.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



The Cost of Medical Latin

Frederic T. Jung, M.D.
Chicago

The cost of medical education includes a great investment of time on the part of the student. Preoccupied with the overtly financial costs, educators may forget that time also has its financial equivalent and that it enters into every student's calculations in some way. For this reason our educational system should be scrutinized occasionally to make sure that waste in this direction is eliminated.

The present article deals with a problem that arises during the secondary or high school period. Shall the prospective medical student spend one fourth of his time, for two or more years, on Latin?

Until recently there were strong arguments in favor of this language. Latin was a close approach to a universal language; it had an immense cultural value; it illuminated the study of the Romance languages and of English; it underlay the vocabulary of medicine, law and theology, and it was supposed, by imparting "mental discipline" and by "transfer of training", to aid in the preparation of the young person for the rigors of his medical studies. Unfortunately, psychologists are accumulating data that cast doubt on the assumed special value of the mental discipline of translating Caesar, and educators are questioning the wisdom of acquiring one skill simply to facilitate the acquisition of a second. It is like warming up for a trip from Chicago to New York by making a preliminary trip to San Francisco.

Coming more specifically to the case of the medical student, it was argued that the medical vocabulary has its roots in Latin (conveniently forgetting Greek for the moment), that the important B. N. A. terminology uses Latin, and that the student cannot afford to be ignorant of this, the universal language of medicine. At this point a vicious circle is recognized: The student is to study Latin because it is a universal language, and it is a universal language because every student is required to study it.

These problems have become more acute since students are entering medical schools with less and less knowledge of Latin or of any other foreign language. This fact will be regretted by those who have experienced the pleasure and illumination that comes from the study of a

second language. Nevertheless the trend cannot be denied. It is also apparently inevitable, for the modern physician is expected to know so much about so many kinds of technical matters that to ask him to clutter his mind with the interminable details of foreign genders, declensions, and conjugations is ridiculous if not criminal. As it is, too much of his time in school is spent in learning the innumerable peculiarities of English spelling.

To give an adequate account of the maladjustments and absurdities that result from the present situation would require more details than would seem appropriate in an editorial, and a few illustrations must suffice. Such illustrations can be assembled with little effort by listening intently to the papers at a single medical meeting or by going over less than a dozen manuscripts as they come to editors of medical publications. At meetings, the oral presentations get immediately into difficulty with words like *naevi* and *plicae*, and one can get a malicious pleasure out of hearing the speaker struggle with terms like *cicatrix, canalis nutricius phalangis, cartilago triticea, corpus vesicae felleae, facies corneae, fascia endopelvina and sacci lacrimales.*

The reason for the speaker's confusion is that every national group has its own rules for pronouncing Latin. The French give the *U* their characteristic sound, roughly that of the German U-umlaut; the Germans pronounce the *C* like *TS* if it precedes a "front vowel"; the Italians pronounce the same *C* like the English *TCH*. In addition to these variations there is the pronunciation of Latin carefully taught in American high schools for decades and generally assumed to represent the diction of the ancient Romans. It has much to recommend it, but differs from all of the foregoing in that the *U* is given a flat sound like the vowel in *moon* and the *C* is always pronounced hard like *K*.

Similar difficulties are encountered by the medical writer. The inadequacy of Latin in meeting the exigencies of modern anatomy is revealed in the labelling of anatomical illustrations in current textbooks. An example from a current textbook for nurses comes immediately to hand: "Inferior colliculus of corpus quadrigemina." The author, aside from joining an adjective in the plural to a noun in the singular, has felt it necessary to insert an English preposition. German textbooks of anatomy are full of legends like "rechtes ganglion oticum", and the preposterous results of mixing French with Latin furnished Moliere with some of the funniest passages in a drama in which he travestied a doctor's examination. There was something half amusing, half pathetic in the long-remembered plea of a clinician at Rush Medical College, "Gentlemen, let us speak either English or Latin!"

Some of the difficulties with Latin arise out of a problem seen also in French, German, and many other languages (with the fortunate exception of English), the problem of irrational genders. The word for "head", for example, is masculine in German (der Kopf), feminine in French (*la tete*), and neuter in Latin (*caput humanum*). Latin even has a noun *dies*, the word for "day", that is feminine in the plural but sometimes masculine in the singular. If the student succeeds in remembering all these irregularities, he must next cope with the problem of the agreement of adjectives with substantives, and must understand why one writes *ramus dexter, manus dextra, corpus luteum, cornu inferius,* and *treponema pallidum.* To form the plurals of phrases like these requires the help of a philologist, and medical writers in their cheerful ignorance are constantly using barbarisms like "this media" and "each labia" or inventing atrocious plurals like "decubiti" and "diverticulae." An outbust of complaints from various scientists about the trouble caused by these linguistic booby-traps appeared in a recent issue of *Science.*

Hope in this situation is offered by the introduction of a new language for international communication, a language happily free from problems of spelling, pronunciation, gender and declension. In this language, students need no spelling books, for words are pronounced as they are spelled and spelled as they are pronounced. It is called Interlingua, and is based on a vocabulary so carefully chosen from roots most frequent in modern languages that scientific literature written in Interlingua can be read immediately with surprisingly little reference to a dictionary. The grammar takes not years to learn but a few hours. A science news letter

(*Continued on page 223*)

KNOW YOUR SOCIETY

COUNCIL COMMITTEES

Following the last meeting of the House of Delegates at each annual meeting, the old Council meets to complete any unfinished business, and adjourns sine die. The new Council convenes and the first order of business, with the secretary of the Society in the chair, is the election of the new Chairman for the coming fiscal year. In June the reorganization meeting of the Council is held. The first duty of the new chairman is the selection of the personnel of all Council committees, and the approval of his appointments by official action of the Council.

This group of committees totals approximately forty. Of this total, three are classified as "Committees within the Council", and are composed of Council members. The Executive Committee of the Council meets prior to the Council sessions, and "clears" material in detail which will be brought before the Council the following morning for action. The chairman of the Council acts as chairman of the Executive Committee. Either he or one of the members appointed by him, reports "recommendations" of the Executive Committee for Council approval — or rejection. The work of the Executive Committee has expedited Council problems, and has made it possible for more work to be accomplished in less time. Membership on this committee is automatic in the cases of the president, chairman of the Council, secretary, chairman of the Finance Committee, and the president-elect. There are other members of the group, appointed by the Chairman.

The Finance Committee, composed of the chairman and two members, acts as the reference group to which all expenditures of funds are referred or recommendation. This committee has the responsibility of recommending salary changes, annual committee budgets, advisability of entering new fields of activity, maintaining solvency for the Society, investing surplus funds for the Society and the Benevolence Committee. All threads of Society activity are gathered into one rope of continuous strength which represents an over-all picture of thought and balance. Under this Committee, your dues are returned to you in services and protections, to the best of the committee's knowledge and ability.

The Advisory Committee on Policy was developed at the request of the secretary, to determine policies when action is necessary during the interim between Council meetings. This Committee serves the Council in the same manner in which the Council serves the House of Delegates. Its membership is composed of the president, the chairman of the Council, the chairman of the Finance Committee and the secretary.

MEDICAL ADVISORY COMMITTEES

The group of medical advisory committees includes (1) Advisory Committee to the Illinois Public Aid Commission, (2) AdvisoryCommittee

to the Veterans' Administration, (3) Advisory Committee to the Illinois Division of the American Legion, (4) Advisory Committee to the United Mine Workers, (5) Advisory Committee on Military Affairs, and (6) Advisory Committee to the Woman's Auxiliary.

(1) The Advisory Committee to the Illinois Public Aid Commission is one of the most active committees of the Council. The committee meets with the Commission Personnel just prior to each meeting of the Council, to discuss and study problems which arise at the county, state and federal level through the months and years. When federal funds are used in any state program, ferderal laws must apply. State laws must be complied with; and county society advisory committees must function to assure the smooth operation of the medical phase of this varied program.

Probably more resolutions have been introduced in the House of Delegates dealing with this program than with any other single problem considered by the Delegates at each annual meeting. The Committee strives to represent the physicians and their interests, to secure for them equitable fees under a legally supervised Commission, and to deal impartially with members of the profession when any abuse of the program develops and is called to the attention of the Committee.

(2) The Advisory Committee to the Veterans' Administration developed the Illinois contract with the Administration which governs the medical care program for veterans in their home towns and provides care for service-connected disabilities by the physician of choice. The secretary's office sends forms to the individual physicians which are filled out, returned and then mailed to the Chicago office of the Veterans' Administration. Physicians desiring to participate in the home-town care plan are paid direct by the government. Certain federal laws apply to this program also. The fee schedule has been printed and when the application card is mailed, a copy of the schedule is provided. Each year the Council considers the contract with the government, and following recommendation by the Advisory Committee, has approved the procedure for another fiscal year.

(3) The Advisory Committee to the Illinois American Legion was appointed by the Chairman of the Council during July of this year. The committee was requested by the Legion, and will function when asked to do so. Other allied professions have also appointed advisory groups to the Legion, and the Council will be most interested in the joint meetings scheduled for the coming year. One member of the Committee is the commander of his local Legion Post, and the general feeling is that the Society will be well represented, and that a spirit of understanding and cooperation can and will be developed.

(4) Advisory Committee to the United Mine Workers functions in an advisory capacity upon the request of the medical department of the United Mine Workers Health and Welfare Fund. Illinois is "under" the St. Louis office of the U. M.W., and the medical director is a former member of the Illinois State Medical Society who has been and is most cooperative. The main function of this Fund is to provide medical care for miners (and their families) in as efficient and liberal manner as possible. The same relationship does not exist between this committee and the U. M. W., as exists between the advisory group and the I. P. A. C. However, when difficulties have arisen in the past it has been possible to arbitrate and work with the Health and Welfare Fund representatives to the advantage of the patients under medical supervision, and to try to develop a fee schedule in keeping with that in the county where such work is under way.

(5) Advisory Committee on Military Affairs works in close cooperation with State Selective Service to maintain an even distribution of medical care in critical areas, and yet supply the armed forces with personnel under the Doctors' Draft Law. All members of the committee are veterans and while lay personnel carries on the rountine work of the committee, the members are consulted judiciously and frequently to determine matters of policy and to assist whenever and wherever possible in supplying physicians to the citizens of the state of Illinois, and to the armed forces of this country.

(6) Advisory Committee to the Woman's Auxiliary has a two fold function: to assist the members of the Auxiliary in their various cooperative activities, and to keep the members of the Illinois State Medical Society informed of the excellent work being done by their wives. The

Auxiliary, under the policy making bodies of the Society, has branched out in many fields. The contributions made by the Auxiliary to the Benevolence Fund were called to the attention of the Society during the annual meeting. The work during the past year in the "get out the vote" campaign throughout the state was excellent and outstanding. The recruitment of young women for the field of nursing has received fine cooperation and attention from the Auxiliary. Members of the local Auxiliary have manned the booths at the Illinois State Fair. New chapters are being organized, and the "membership at large" throughout the State has been growing phenomenally during the past year. The Bulletin, sent to all members of the Auxiliary and key members of the Illinois State Medical Society, has fostered cooperation and growth in established county auxiliaries and in new areas.

MEDICAL LATIN (Continued)

now appears monthly, and physical tables are being published. A dictionary and an introduction to the grammar are available.

A second hopeful sign is the announcement of an impending revision of the Basel Anatomical Nomenclature. The establishment of the B. N. A. in 1895 was something for which the medical student today should be profoundly grateful. It may, however, turn out not to have been the last step needed in order to provide a universal, rational, easy vocabulary for anatomy. It is to be hoped that the revision committee, under the chairmanship of Prof. T. B. Johnston of London, will assume the responsibility of supplying the medical world with the equivalent of the B. N. A. in Interlingua. If this can be done, there should result not only a reduction of errors in medical publications but also a saving of the medical student's time. And time is money.

PROCTOLOGIC AWARD

The International Academy of Proctology announces the establishment and award of a one year Proctologic Research Fellowship in the amount of $1200.00. This Research Fellowship grant has been awarded to the Jersey City Medical Center, New Jersey, to be administered under the direction of Dr. Earl J. Halligan, Surgical Director of the Medical Center.

Dr. Halligan is a former International President of the Academy. The Board of Trustees of the International Academy of Proctology will vote another Fellowship grant of a similar amount at the time of the next annual meeting of the Academy. Thus, there will be at least two Research Fellowship studies in progress, in different institutions, under the auspices of the International Academy of Proctology.

STEROIDS AND POTENCY

It has been observed that androgens or estrogens relieve mental depression in either sex. Vasomotor instability in both sexes responds satisfactorily to their use in most cases. Psychogenic amenorrhea has been reported by Reifenstein to be accompanied by decrease in the urinary excretion of 17-ketosteroid. British neurosurgeons have observed that impotent patients on whom they performed prefrontal lobotomy experienced a resumption of potency and an increase of 17-ketosteroid from zero to normal value. Stress and anoxia produce adrenal secretion of cortisone through hypothalamic action. Testosterone is anabolic in so far as muscle tissue metabolism is concerned. Patients suffering from senile dementia sometimes recover when testosterone is given. Testosterone favorably influences breast cancer in the female in some cases. Testosterone has rejuvenated and made winners of old horse races. Unfreshened cows will lactate when given stilbestrol. Diabetes is favorably influenced by the administration of estrogen or by castration. Patients who suffer from rheumatoid arthritis are spectacularly relieved and inflammatory tissue changes have proved reversible following the administration of cortisone and ACTH. *William P. Herbst, Prostate and Metabolic Research. Med. Ann. District of Columbia, July 1953.*

RHEUMATIC DISEASE ABSENTEEISM

In this company (Consolidated Edison Company), employing approximately 25,000 persons, about 4,200 work days have been lost per year because of rheumatic diseases. Assuming that this employee group is representative of employees throughout the country, we can estimate that in the United States, with 62 million gainfully employed, the average work days lost would approximate 10,500,000 per year. *Joseph J. Bunim, M.D., The Incidence Of Rheumatic Diseases In Industry. Indust. Med., July 1953.*

PROFESSIONAL RETICENCE

A doctor's wife is ever ready with the diverting or equivocal reply to an embarrassing question. At bridge. an overbearing dowager may ask her, "What do you think is the cause of that awful lumbago the Vicar gets?" Without batting an eyelid, the doctor's wife will carry on with the game. "One spade," she calls. Or, "Now tell me what is really the matter with Miss Thistledown?" "Two hearts." *C. G. Learoyd, M.R.C.S., L.R.C.P., The Doctor's Wife, practitioner, June 1953.*

CORRESPONDENCE



AUXILIARY PRESIDENT'S MESSAGE

As we begin this second quarter century of our existence, I wish to extend greetings to each member of the Woman's Auxiliary to the Illinois State Medical Society.

We are filled with gratitude and anticipation. Gratitude to that small group of determined courageous women, who could vision the inestimable value of an Auxiliary.

Anticipation that the aims and ideas of the founders not only be carried out, but enlarged upon.

I trust that each doctor's wife will feel that it is not only an obligation, but a privilege to belong to the Auxiliary. If you live in a county which has no organization, we welcome you as a member-at-large.

The Auxiliary, because of its sound foundation, can assist in meeting problems brought about by social and economic changes.

Make the most of your contacts with other groups. Plan your schedule to include time for Parent Teachers Association, Scouting, Red Cross, Blood Bank and many others.

Be well informed on current medical topics and able to answer questions intelligently. You are expected to know the answers. However, let us be prudent, remembering what our mythical Indiana writer, Abe Martin, says. "Sometimes it is good to keep quiet even if you know what you are talking about."

We can be proud of the part the Auxiliary has played in establishing and helping to maintain the Benevolence Fund. I feel sure that our contributions to this most worthy cause shall not only continue but increase.

As I begin this year of service, I seek the advice and cooperation of each individual member. This is the only way that it is possible for us to go forward.

Mrs. Henry Christiansen

CLINICS FOR CRIPPLED CHILDREN LISTED FOR OCTOBER

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will conduct 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 6 — Flora, Clay County Memorial Hospital

October 7 — Hinsdale, Hinsdale Sanitarium

October 8 — Cairo, Public Health Building

October 8 — Springfield, St. John's Hospital

October 8 — Sterling, To be announced prior to clinic

October 8 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

October 9 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 13 — Danville, Lake View Hospital

October 13 — Quincy, Blessing Hospital

October 13 — Peoria, St. Francis Hospital

October 13 — East St. Louis, St. Mary's Hospital

October 14 — Elgin, Sherman Hospital

October 15 — Litchfield, St. Francis Hospital

October 21 — Chicago Heights, St. James Hospital

October 22 — Bloomington, St. Joseph's Hospital

October 22 — Mt. Vernon, Masonic Temple

October 22 — Rockford, St. Anthony's Hospital

October 23 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 27 — Effingham (Rheumatic Fever), Douglas Township Building

October 27 — East St. Louis, Christian Welfare Hospital

October 27 — Peoria, St. Francis Hospital

October 28 — Springfield (Cerebral Palsy), Memorial Hospital

October 28 — Alton, Alton Memorial Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

CONVENTION OF THE GASTRO-ENTEROLOGICAL ASS'N.

The National Gastroenterological Association will hold its eighteenth anuual convention and scientific session at the Biltmore Hotel in Los Angeles on October 12, 13, 14, 1953.

The program will include a Symposium on Cirrhosis of the Liver; Panel Discussions on "Peptic Ulcer"; "Diseases of the Large Bowel" and "Latest Developments in Cancer Research".

Following the convention, on October 15, 16, 17, 1953, the association's fifth annual course in Postgraduate Gastreoenterology will be given at the Biltmore Hotel and the College of Medical Evangelists in Los Angeles. The course will be under the personal direction of Drs. Owen H. Wangensteen of Minneapolis, and I. Snapper of Chicago, who will be assisted by a faculty from the medical schools in and around Los Angeles.

The Scientific Sessions on October 12, 13 and 14 are open to all physicians without charge.

MEDICAL RESERVIST TO EARN POINTS ATTENDING SURGEONS MEETING

Reserve credit points may be earned by Medical Service reserve officers on inactive duty for attendance at the daily sessions of the forthcoming 60th annual meeting of the Association of Military Surgeons, the Department of Defense announced today.

This authorization covers eligible physicians, dentists, veterinarians, nurses, women's medical specialists, and Medical Service Corps Officers of the U. S. Army, Navy, and Air Force Reserves.

Rear Admiral Winchell Mck. Craig (MC) USNR, President of the Association, will open the meeting at 9 a.m., Monday, November 9, 1953, in the Presidential Ballroom of the Statler Hotel, Washington, D. C., by introducing the senior officers of the various Federal medical and health agencies. The scientific portion of

the program will follow and continue through Wednesday, November 11.

Point credits will be awarded to eligible reserve officers on the basis of one point for each day of attendance, provided sessions attended total more than two hours. Each day of the meeting will be considered a session.

Reserve officers will be required to register for each day's session by presenting themselves to representatives of their respective services at the registration desk. Properly authenticated reports of attendance will be rendered to all Army Headquarters, Naval Districts and the Naval Reserve Officers Performance Recording Unit, and numbered Air Force Headquarters to assure creditation.

The meeting will be devoted to subjects having direct military application and will provide an excellent opportunity for Reserve officers to earn Reserve credit points while being brought up-to-date on the latest developments of military medicine.

PRIZE ESSAY ON CARDIAC SURGERY

The Trustees of one of American's oldest medical essay competitions, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's prize dissertation "Recent Advances In Cardiac Surgery". The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

AMERICAN DERMATOLOGICAL ASS'N. PRIZE ESSAY CONTEST

The American Dermatological Association is again offering a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphiology. The purpose of this contest is to stimulate investigators to original work in these fields. Cash prizes will be awarded as follows: Five hundred dollars, three hundred dollars and two hundred dollars for first, second and third place, respectively.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts, and tables, all of which must be in triplicate, are to be submitted *not later than December 1, 1953.* The manuscripts should be sent to Dr. J. Lamar Callaway, Secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina. Those which are incomplete in any of the above respects will not be considered.

DIRECTORY OF MENTAL HEALTH RESOURCES

The most recent edition of the Directory of Mental Health Resources in Illinois is now available from the Illinois Society for Mental Health. Prepared as a community service for health and welfare agencies, this 84-page publication carries information of value to doctors, nurses, social workers, teachers, and others, such as clergymen, lawyers, and personnel officers, who are responsible for making appropriate referrals.

The Directory includes descriptive listings of: general hospitals with psychiatric units, guidance and counseling services, out-patient clinics, private sanitariums, public hospitals, residential treatment centers for children, and rest homes for mental patients; also, day and residential schools for the mentally retarted. Finally, it defines the mental health programs of administrative and coordinating agencies throughout the State of Illinois.

The Directory, which sells at $1.50 per copy, may be obtained from the Illinois Society for Mental Health, 123 West Madison Street, Chicago 2.

INSTITUTE ON RHEUMATIC FEVER

An annual institute on rheumatic fever will be held at La Rabida Sanitarium on October 12 to 16, 1953.

The institute will cover the subject of rheumatic fever and rheumatic heart disease. It will be conducted for four days by members of the hospital staff, together with others selected from the medical schools in this city with which the hospital is affiliated, and by several invited guests. It will be directed primarily to the general practitioner or family physician and to nurses, medical social workers, occupational therapists, dentists and others with a similar interest in the subject. There will also be a scientific session on the fifth day, October

16th. On that day the first Robert A. Black Memorial Lecture will be given.

Advance registration will be required for those who wish to attend. Visitors to individual sessions will be admitted by card on previous application. There will be no admission or tuition charge.

Further information will be supplied by circular or application to Institute, La Rabida Sanitarium, East 65th St. and South Shore Drive, Chicago 49, Illinois.

AMERICAN COLLEGE OF SURGEONS

The largest meeting of surgeons in the world, the 39th Annual Clinical Congress of the American College of Surgeons, will be held in Chicago October 5 to 9, 1953. More than 11,000 surgeons, physicians and others will attend. Headquarters will be The Conrad Hilton Hotel.

Subjects of the increasingly important graduate courses, to be conducted by leading surgeons, are pre and postoperative care, surgery of the upper gastrointestinal tract, surgery of the small and large bowel, cardiovascular surgery, obstetrics and gynecology, and trauma to the abdomen.

Surgical procedures at Albert Merritt Billings Hospital will be televised in color to the Conrad Hilton each day. Smith, Kline and French Laboratories of Philadelphia are sponsors of this program.

Twelve forums on Fundamental Surgical Problems, presenting the latest research findings, mainly by younger surgeons, will be held Monday through Friday.

Symposia on cancer, trauma, graduate training in surgery and the surgical specialties and a motion picture symposium on "Unusual Conditions in Abdominal Surgery" will be featured during the week.

MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING

The annual meeting, Mississippi Valley Medical Society, will be held at the Elk's Club, Springfield, Ill., Sept. 23-25.

The meeting will feature 41 speakers and over 40 scientific and technical exhibits in an intensive 3 day session with the entire program geared to especially appeal to men in general practice. The program will include a Symposium on Diabetes, a Clinico-Pathologic Conference and a Panel on "What is New in Medicine and Surgery." There will be clinical teachers from the Universities of Illinois, Iowa, Louisville, Oklahoma, Tennessee, and from Northwestern, St. Louis, and Washington Universities. The Sept. 24 evening program will feature a presentation of awards and fellowships with the principal address by Assistant Secretary of Defense (Health and Medical) Dr. Melvin A. Casberg of Washington, D. C., formerly Dean of St. Louis University. A detailed program may be secured from Harold Swanberg, M. D., Secretary, W. C. U. Bldg., Quincy, Ill. All ethical physicians are cordially invited to attend. There are no registration fees.

1954 COLLEGE ESSAY AWARD

The Board of Regents of the American College of Chest Physicians offers three awards to be given annually for the best original contribution, prepared by any medical student studying for the degree of Doctor of Medicine, on any phase relating to the diagnosis and treatment of chest disease.

The first prize will consist of a cash award of $250 and a certificate. The second and third prizes will be certificates of merit. The essay award is open to all medical students in accredited medical schools throughout the world.

The winning contributions will be selected by a board of impartial judges and will be announced at the 20th annual meeting of the American College of Chest Physicians to be held in San Francisco, California, June 17-20, 1954. All manuscripts become the property of the American College of Chest Physicians and will be referred to the Editorial Board of the College journal *Diseases Of The Chest* for consideration. The College reserves the right to invite the winner of the first prize to present his contribution at the annual meeting.

Applicants are advised to study the format of *Diseases Of The Chest* as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. For information write Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than March 15, 1954.

NEWS OF THE STATE



CLINTON

Evening Covered Dish Picnic.—Members of the Clinton County Medical Society, wives and children held a covered dish picnic, the evening of June 10, on the farm of Dr. E. C. Asbury. Special features were fried chicken and baked beans.

COOK

Edward Compere Named Head of Department.—Dr. Edward L. Compere has been appointed chairman of the department of bone and joint surgery at Northwestern University Medical School, effective September 1. He succeeds Dr. Philip Lewin who will retire. Dr. Compere has been a member of the Northwestern University faculty since 1941.

Pediatric Fellowship Granted.—Dr. Roberto Ortiz, a citizen of Costa Rica, has been awarded the Florence Olmstead Memorial Fellowship, which will enable him to carry on graduate work in pediatric surgery at Children's Memorial Hospital. Funds to support the fellowship are raised at the annual benefit of the Women's Faculty Club of Northwestern University Medical School. In 1952, the benefit was a tribute to Dr. Isaac A. Abt, pioneer Chicago pediatrician. The 1953 benefit will be held October 13.

Allergists Choose New Officers.—At a recent meeting of the Chicago Society of Allergy, Dr. Max Samter, Oak Park, was chosen president-elect, Dr. Abe L. Aaronson, Chicago, was installed as president, and Dr. Simon S. Rubin, Gary, Ind., was reelected secretary.

Roger Baker Goes to Washington.—Dr. Roger Baker, head of the division of urology, University of Chicago School of Medicine, has accepted the post of professor of urology and head of the department at Georgetown University School of Medicine, Washington, D. C.

Call for Musicians.—About forty physicians have responded to an appeal for an expression of interest in the formation of a Physicians' Symphony Orchestra in the Chicago metropolitan area. Physicians interested in the organization of such a project are requested to send their name, address, telephone number and name of instrument to J. W. Fischer, M.D., Chairman, 109 North Wabash Avenue.

Personal.—Dr. Duncan D. Campbell has been named acting superintendent of Chicago State Hospital, it was reported July 31, succeeding Dr. Edward F. Dombrowski.

Chicago Physician Goes to Africa.—Dr. Titus M. Johnson was to have left late in August for Tandala, Ubangi, Belgian Congo, where he will supervise the completion and operation of a fifty bed hospital now under construction by the Evangelical Free Church of America. The physician and his wife plan to stay in the Congo for about eighteen months, newspapers reported.

Name New Members to Advisory Committee for Crippled Children.—Appointment of seven new members to the Professional Advisory Committee of the Division of Services for Crippled Children has been made by the University of Illinois Board of Trustees.

The new committee members will serve terms of two years. The appointees are Dr. Floyd Barringer, Springfield neurosurgeon; Dr. Gerald M. Cline, Bloomington pediatrician; Mrs. Carol H. Cooley, Health Division, Welfare Council of Metropolitan Chicago; Dr. Francis L. Lederer, head of the Department of Otolaryngology, University of Illinois College of Medicine; Dr. John H. Mathis, Peoria urologist; Dr. Robert H. Rutherford, Peoria internist; and Dr. L. D. Ruttle, Joliet anesthesiologist.

The Board of Trustees also has reappointed 30 others to the Committee.

The Division of Services for Crippled Children of the University of Illinois is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which lead to crippling.

The Professional Advisory Committee works with Dr. Herbert R. Kobes, director of the Division, in regard to the Division's operation. Matters concerning professional activities influencing the care of crippled children are considered periodically. The Committee sets standards for professional personnel and facilities, and advises on policies which concern methods of providing care.

Contribution to Ricketts Fund.—A nest egg that has grown in 53 years to $7,600 has been given to the University of Chicago.

Begun in 1900 after the marriage of the late Dr. and Mrs. Howard Taylor Ricketts, the nest egg has been added to the Howard Taylor Ricketts award fund at the University to recognize outstanding medical work throughout the United States.

Mrs. Ricketts, who died last January, began the fund with her savings from the household budget of her husband, the University of Chicago assistant professor who discovered the organism that causes typhus fever. Ricketts, a promising young assistant professor of pathology, proved, during the 1906 epidemic of Rocky Mountain spotted fever, that the disease was conveyed to man by a tick. Three years later, he discovered the causitive organism now named in his honor.

Dr. Ricketts' success in this research led him to Mexico to investigate Mexican typhus fever, a disease with a high mortality rate and somewhat similar to the Rocky Mountain spotted fever.

At Dr. Ricketts' death, of typhus fever, in Mexico City, May 3, 1910, Mrs. Ricketts added her husband's bank balance to the nest egg. She also added to the saving odd sums of money to which special or sentimental interest was attached, including the school prizes of her children, Dr. Henry T. Ricketts, now professor of medicine at the University, and Mrs. Walter L. Palmer, wife of a University of Chicago doctor.

At the University of Chicago, the nest egg has been added to the Ricketts fund, established in 1949 by Mrs. Ricketts, to endow the Ricketts medal.

Since its establishment, the Ricketts medal has been awarded on the anniversary of Dr. Ricketts' death to: Dr. Russell Wilder, Mayo Clinic; the late Dr. Ludwig Hektoen, University of Chicago; Dr. S. Burt Wolbach, Harvard University; Dr. Herald R. Cox, Lederle Laboratory; Dr. Thomas Francis, Jr., University of Michigan; and Dr. Joseph E. Smadel, Walter Reed Army Medical Center.

McLEAN

Society News.—Lawrence W. Rember, director of field services, Department of Public Relations, American Medical Association, will address the McLean County Medical Society at the Rogers Hotel in Bloomington, November 10. His subject will be "Making Patients Happy."

WINNEBAGO

Personal.—Col. Roland I. Pritikin, Rockford, was to attend the seventh International Congress of the History of Science, Jerusalem, Israel, August 3-7, as a representative of several medical societies.

GENERAL

Fellowship Created for Study in Proctology.—The International Academy of Proctology announces the establishment and award of a one year Proctologic Research Fellowship in the amount of $1200.00. This Research Fellowship grant has been awarded to the Jersey City Medical Center, New Jersey, to be administered under the direction of Dr. Earl J. Halligan, Surgical Director of the Medical Center.

Dr. Halligan is a former International President of the Academy. The Board of Trustees of the International Academy of Proctology will vote another Fellowship grant of a similar amount at the time of the next Annual Meeting of the Academy. Thus, there will be at least two Research Fellowship studies in progress, in different institutions, under the auspices of the International Academy of Proctology.

"Your Doctor Speaks" over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks", presented by the **Educational Committee** of the Illinois State Medical Society in cooperation with FM Station WJFL:

Walter J. Reich, attending gynecologist and obstetrician, Grant Hospital, July 30, Cancer of the Female Organs.

Benjamin Pearlman, assistant clinical professor of medicine, University of Illinois College of Medicine, August 6, Misconceptions Regarding Disease.

Harry E. Mock Jr., instructor in surgery, Northwestern University Medical School, August 13, Internal Injuries.

Lectures Arranged Through the **Educational Committee** of the **Illinois State Medical Society:**

Earle E. Wilson, Oak Park, Elmhurst Kiwanis Club in Elmhurst, August 18, on Your Mental Health.

Peter J. Cotsirilos, Komarek School District in North Riverside, September 3, on What Teachers Should Observe in A Child When Healthy or Ill.

Eugene L. Slotkowski, Komarek School District, September 3, on Understanding and Knowing What to Do for the Child Whose Behavior is Beyond Normal Range.

Alfred Flarsheim, Mother's Club of St. Paul's

Church in Chicago, September 15, on Psychosomatic Medicine.

James A. Schoenberger, Young Married Couples' Sunday Evening Club in Chicago, October 4, Atomic Medicine.

Bernice S. Rosen, Austin Jewish Community Center in Chicago, October 21, on Frigidity in Women.

George M. Cummins, Jr., Forty-First Safety Congress of the National Safety Council, October 21. Geriatric Factors in Home Accidents.

Hugh A. Flack, Toman Library Forum in Chicago, October 30, Knowing Your Heart.

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Kenneth C. Johnston, Chicago, La Salle County Medical Society in Ottawa, October 8, on Diseases of the Trachea.

Frederick H. Falls, Chicago, Bureau County Medical Society in Princeton, October 13, on Radiological versus Surgical Treatment of Carcinoma of the Uterus.

Ford K. Hick, Chicago, Knox County Medical Society in Galesburg, October 15, on Use of Slow-Acting Insulins.

George M. Cummins, DeKalb County Medical Society in DeKalb, October 27, on Medical Aspects of Aging.

Edward Massie, St. Louis, Montgomery-Macoupin CountyMedical Societies in Litchfield, October 27, on Recent Developments in Coronary Artery Disease and Its Management.

DEATHS

Otho F. Ball, Chicago, who graduated at St. Louis College of Physicians and Surgeons in 1897, died July 19, aged 78. He was president of the Modern Hospital Publishing Company.

Lloyd V. Boynton, retired, Peoria, who graduated at St. Louis University School of Medicine in 1906, died July 12, aged 73. He practiced medicine in Vermont, Illinois, for eighteen years before moving to Peoria, where he practiced until his retirement in 1950.

Leo Clifford Clowes, Hinsdale, who graduated at Rush Medical College in 1923, died June 10, aged 62, by drowning when he was swept into deep water by swollen currents in the Fox River near Millbrook, while fishing. He served as instructor in surgery at the University of Illinois College of Medicine, and was a member of the staffs of Cook County Hospital and Hinsdale Sanitarium.

Loren Leslie Collins, Edwardsville, who graduated at the University of Illinois College of Medicine in 1925, died May 1, aged 52. He was a member of the American Trudeau Society; past president of the Mississippi Valley Trudeau Society; superintendent and medical director of the Madison County Tuberculosis Sanatorium; formerly medical director of the LaSalle County Tuberculosis Sanatorium in Ottawa.

Isaac Val Freedman, retired, Chicago, who graduated at Chicago College of Medicine and Surgery in 1909, died August 3, aged 71.

Newell C. Gilbert, Chicago, who graduated at Northwestern University Medical School in 1907, died August 1, aged 72. He was senior attending physician at St. Luke's Hospital, and emeritus professor and chairman of the Department of Medicine at Northwestern University. He was also former editor of the Archives of Internal Medicine and former chairman of the Chicago Heart Association.

Fred W. Graham, Morris, who graduated at the Chicago Medical School in 1923, died July 14, aged 70.

John Buford Jennings, Peoria, who graduated at Chicago College of Medicine and Surgery in 1916, died May 22, aged 62, of uremia and gastric hemorrhage.

James L. McCormack, retired, Newton, who graduated at St. Louis College of Physicians and Surgeons in 1892, died May 30, aged 88, of pulmonary edema.

John C. Purvey, Crystal Lake, who graduated at the University of Illinois College of Medicine in 1939, died recently, aged 39.

Sidney C. Rosenfeld, Chicago, who graduated at the Chicago Medical School in 1937, died July 26, aged 46. He was a member of the staff of American Hospital.

Sereno Watson Schneck, Mount Carmel, who graduated at Northwestern University Medical School in 1898, died April 21, aged 78.

Benjamin Maurice Wallin, Chicago, who graduated at College of Physicians and Surgeons of Chicago School of Medicine of the University of Illinois, in 1907, died in Rochester, Minnesota, aged 65, of carcinoma of the lung.

Clarence L. Wheaton, Chicago, who graduated at Bellevue Hospital Medical College, New York, in 1896, died June 3, aged 80. He was former instructor of medicine at Rush Medical College and attending physician in the department of tuberculosis at Iroquois Memorial Hospital.

William T. Winters, retired, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1902, died July 26, aged 86. He was formerly a member of the staff of Garfield Park Hospital.

Charles E. York, Chicago, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1917, died recently, aged 64. He was a member of the staff of the Illinois Masonic Hospital.

Joseph Zabokrtsky, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died July 12, aged 79. He was a member of the staff of St. Anthony's Hospital for 40 years, and was a past president of the hospital board.

ENGLISH IDEAS ON GROUP PRACTICE

To enjoy a larger freedom, a smaller one often must be relinquished and this certainly applies in group practice. Although created as a means to an end, it soon becomes apparent that "the firm" is an entity distinct from any one of its creators. It is the servant of the united will of its members but the maintenance of this essential unity calls for a considerable amount of self-discipline. Loyalty to "the firm" must be of the type that can never be exacted — only freely given. This type of loyalty is encouraged where there is trust, friendliness, and equality of responsibility and income between the partners. But if "the firm" is to be a servant and not a taskmaster it is essential that the partners should be likeminded in many respects. To take an extreme example, it would be disastrous for a doctor wanting an income of 2,500 pounds, and prepared to work hard for it, to team up with one who is prepared to take half that income if he can be assured of three days a week of fishing. The choosing of a partner, therefore, calls for the utmost care and should be determined by considerations of temperament and character no less than of professional competence; nor will the wise man fail to assess the type of influence the prospective partner's wife will have from her position in the home. *J. Guy Ollerenshaw, M.D., Ch.B., Group Practice: Present and Future. Practitioner, June 1953.*

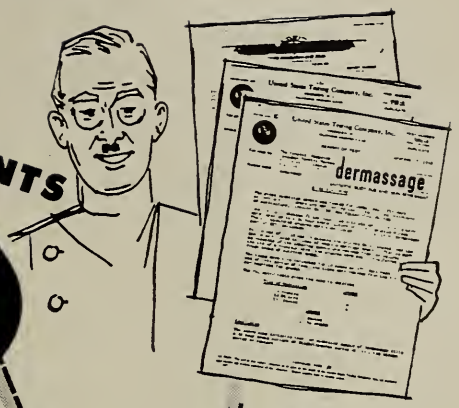
CAT SCRATCH DISEASE

Enough information on cat scratch disease has now appeared in the medical literature so that we can know a fraction more than the readers of Time magazine. The condition was first reported by Debre in Paris in January 1950, though Foshay of Cincinnati had collected a score of cases in the previous 20 years. Sixty cases were reported by Daniels and MacMurray in April 1952 from 15 states, Canada, and Hawaii. Cat contact has occurred in 55 cases, cat scratch in 33 cases, and cat bite in 3 cases. Sixteen were involved in 7 household epidemics. Suppuration occurred in 33 per cent. Lymphadenopathy was general, and lasted from 2 to 26 weeks. Foshay showed the pus was sterile but it could be used to produce an antigen which gave a specifically positive skin test. A case is reported by Quinn which had a positive skin test, a duration of 8 weeks, and an apparent response to terramycin. *Guillermo Olser, M.D., Topics Of Current Medical Interest. Arizona Med. March 1953.*

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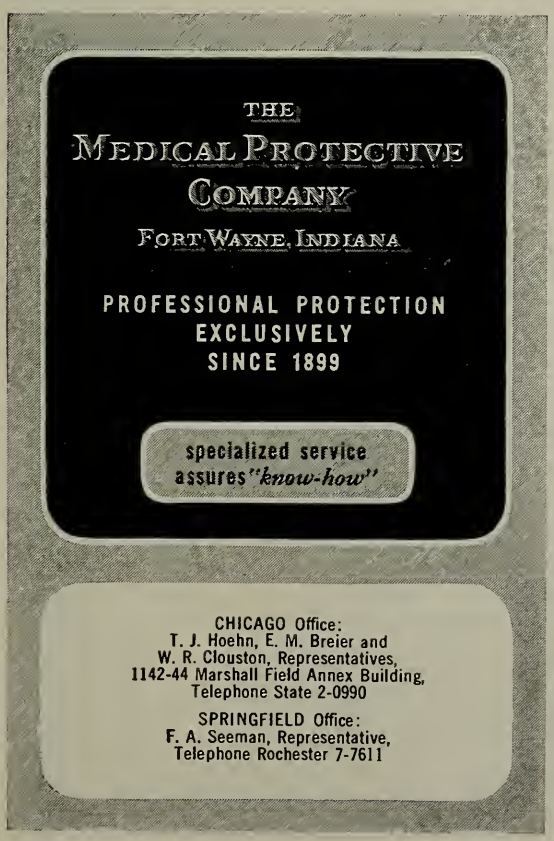
COUNTY SOCIETIES

This list is corrected in accordance with the best information obtainable at the date of going to press. County Secretaries are requested to notify The Journal of any changes or errors.

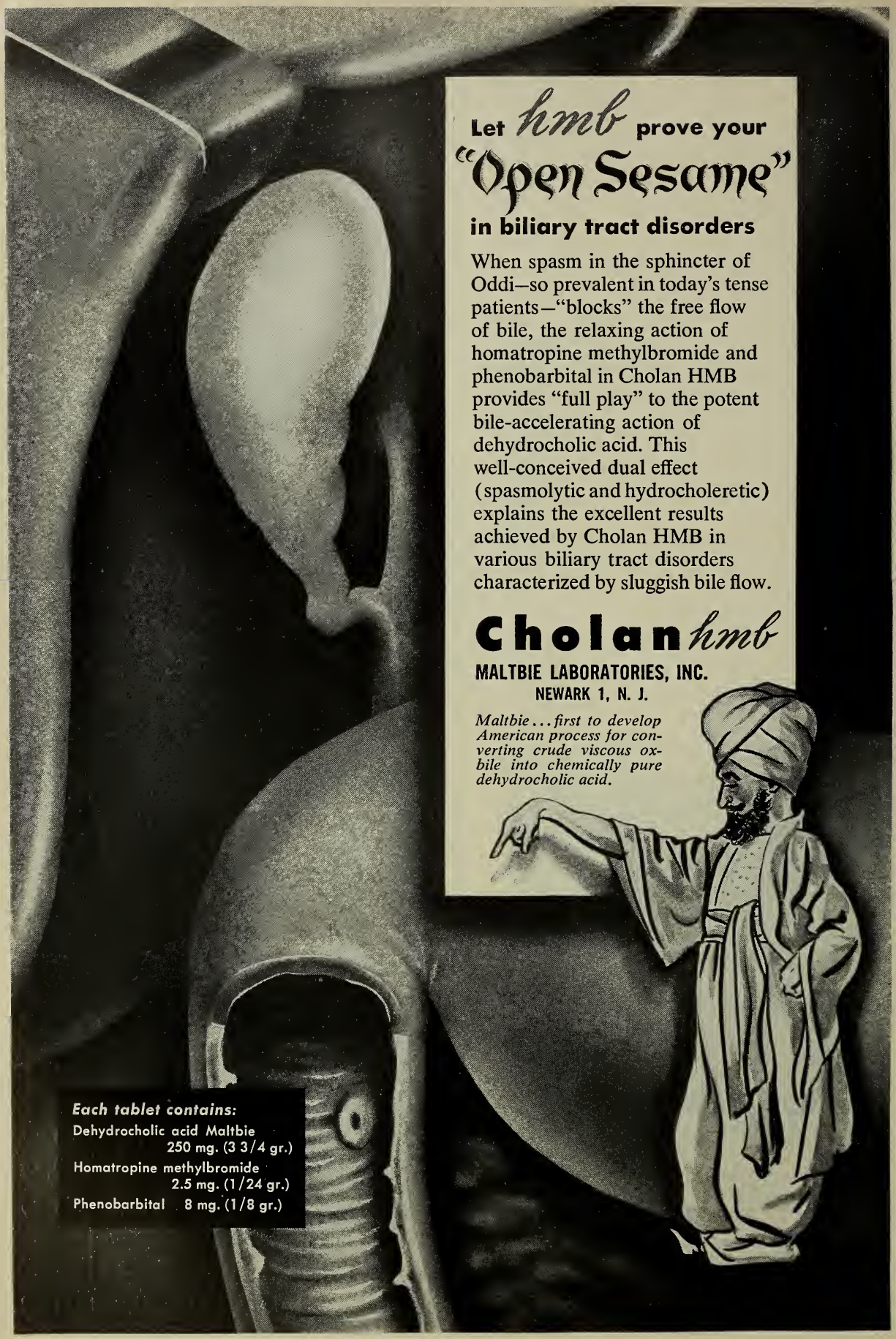
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Lake	W. R. Darnall, 214 N. Sheridan Road, Waukegan	Gerrit Dangremond, 4 S. Genesee, Waukegan
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McDonough	R. L. Franck, Bushnell	W. W. Holland, Macomb
McHenry	A. D. Leschuck, Hebron	Frank L. Alford, Crystal Lake

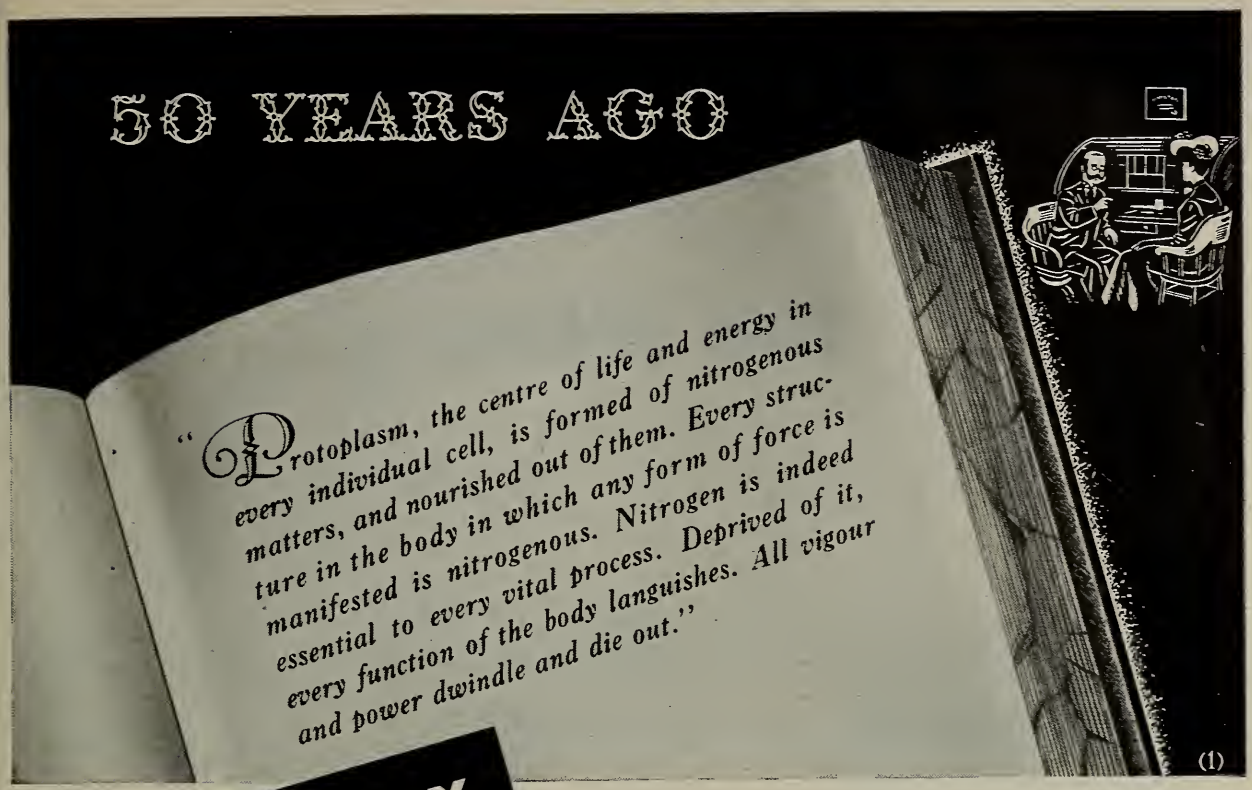
Continued on page 54

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(1) Cheadle — *Artificial Feeding and Food Disarders of Infants*, Sixth Edition, (1906)
(2) National Research Council—*Recommended Dietary Allowances*, Reprint 129, (1949)

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BOOK REVIEWS



THERAPEUTICS IN INTERNAL MEDICINE Edited by Franklin A. Kyser, M.D., F.A.C.P. Assistant Professor of Medicine, Northwestern University Medical School, Chicago. Second Edition, completely revised and reset 830 pages; 1953 Paul B. Hoeber, Inc., New York City, N. Y. Price $15.00.

The editor has enlisted the assistance of eighty four authorities in the revision of this fine book. The first edition was published in 1950, and the complete revision seemed necessary on account of the many new therapeutic agents which have been developed during the past three years. The treatment of medical diseases has been an important function for the busy physicians, and an up to date book on therapeutics is quite important in every office.

Although individual preference on the part of the contributors has been stressed, other common accepted practices are well discussed in the book. It was the original intention in presenting the first edition of the book in 1950, to conform principally to the treatment of medical disease, yet not overlooking the highly important etiologic, physiologic and pathologic factors.

The book is divided into 18 chapters, the first dealing with infectious diseases, those due to viruses, those due to bacteria, Rickettsial diseases, Bartonella disease, Protozoan diseases, and Diseases of doubtful origin. Then in turn in succeeding chapters, the entire field of medical diseases is well covered. Twelve new sections appear in the second edition, and seventeen new contributors have been added to the previous list.

The book should be of much value to every physician, and especially the ever increasing number of general practitioners throughout the nation. The format, and general arrangement of the text, makes it easy for the busy practitioner who is desirous of having a quick reference work available at all times.

CLINICAL ENDOCRINOLOGY, by Lewis M. Hurxthal, M.D., F.A.C.P. and Natalija Musulin, B.S., M.D. J. B. Lippincott Company, Philadelphia, 1953. Two Volumes, 482 figures, 146 charts, 1 color plate. 1599 pages with 2 end pages of laboratory data (these give the normal findings for those tests likely to be helpful in endocrine studies). Price $24.00.

This is truly a monumental work. Written in outline form, it enables the reader to find what he wants with a minimum of effort. This reviewer has had some acquaintance with the senior author for many years. The size and scope of this work is so impressive that he wrote Dr. Hurxthal asking how long it took to complete it and some of the details of the work. The following is taken from Dr. Hurxthal's reply:

"The story of writing the book is of interest. I became particularly interested in Endocrinology when Dr. Horrax, our Neurosurgeon came here around 1934 or 1935, bringing with him patients with pituitary disease. About that time I made a one hour motion picture on Endocrinology and J. B. Lippencott Company saw this when I had an exhibit in Atlantic City, I believe in 1936. They kept after me for three or four years and finally I decided that I would make the attempt, never anticipating that it would end up in such a voluminous book. I really began collecting material for it in 1940 or 1941 and I got so involved that I found it almost impossible to find time enough to do adequate library work and for this reason Dr. Musulin was taken on to spend half her time on refer-

(*Continued on page* 58)



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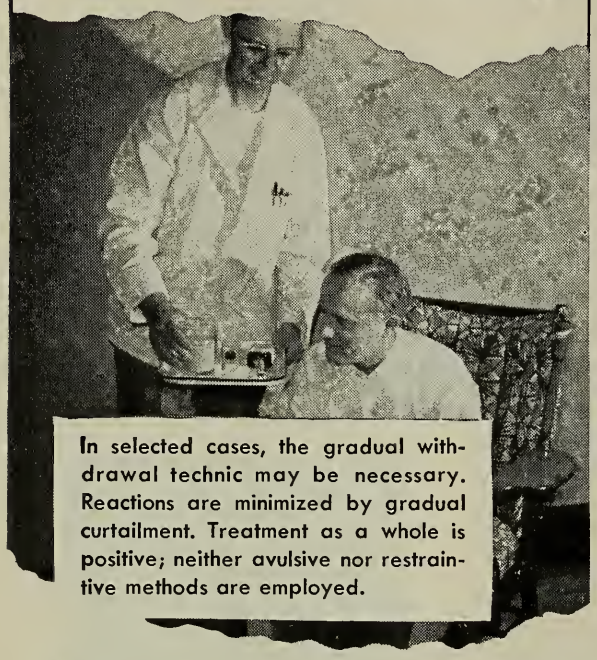
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BOOK REVIEWS (Continued)

ence work in the library. She is responsible for the history, anatomy, histology in a good bit of the preclinical sections.

"The book was about ready to be published when ACTH and Cortisone came along and this of course made it necessary to revise some of our chapters and to add the final chapter on the use of chorionic and pituitary hormones. It was almost impossible to keep it up to date and the book was submitted over two years ago but was revised whenever galley proofs came along.

"The book was written evenings, Saturday afternoons, Sundays and Holidays, along with a very busy schedule. Looking back it seems incredible that we ever finished it.

"The book is a little difficult to get onto, but the publishers could not put it down in any other way. The outline was prepared before the book was written, adding a few things from time to time. One of the objections I had with many books was that the thing I wished to look up could not be found and even though some of our data may be irrelevant, nevertheless it was filled in whenever we could get any information.

"The publishers wanted to have it in one volume but found it could not be done."

The organization of the book is a bit confusing. The reader will save himself time and effort by getting acquainted first with its organization. Once this is understood, one can quickly and easily find the subject sought.

The economy of words has already been mentioned. However, there are of necessity references to negative or unimportant findings. Even these are so arranged that the reader can skip them with hardly a pause in his reading.

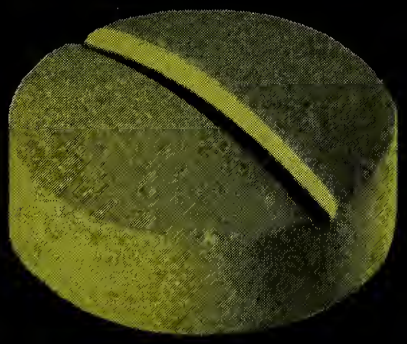
While most endocrinologists will probably wish to add this to their library, it will be equally or possibly more valuable to those practitioners whose chief interest is in other fields of medicine, to whom endocrinological problems are but a complication to their daily work. It will furnish a ready and, for those men, a rather complete reference book.

It is well indexed. The bibliography is conveniently arranged and seems sufficiently complete for practical purposes. The type and paper are of such size and quality as to make for easy reading. It would have been more convenient for readers if the material could have been contained in one volume, but, as Dr. Hurxthal points out, that could not be done.

J. H. H.

The antituberculosis movement synthesized in one single crusade the efforts of sociologists, humanitarians, and hygienists to improve the fate of the destitute by social reforms; to strengthen the human body by advocating a healthy way of life; to control infection by tracking and destroying the tubercle bacilli. Rene J. Dubos, M.D., The American Review of TB, July, 1953.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

MEDICAL SCHOOLS IN THE UNITED STATES AT MID-CENTURY — A Comprehensive Self-evaluation of Today's Medical School. By John E. Deitrick, M.D., Director of the Survey of Medical Education, Magee Professor of Medicine and Head of the Department, Jefferson Medical College and Hospital, and Robert C. Berson, M.D., Associate Director of the Survey of Medical Education, Assistant Dean and Assistant Professor of Medicine, Vanderbilt University Medical School. McGraw-Hill Book Company, Inc., New York, Toronto, London, 1953. $4.50.

BCG VACCINATION — Studies by the WHO Tuberculosis Research Office, Copenhagen — Report prepared under the direction of Lydia B. Edwards, M.D., Chief of Field Studies and Carroll E. Palmer, M.D., Ph.D., Director, with the assistance of Knut Magnus, cand. act. Assistant Statistician, Tuberculosis Research Office, World Health Organization, Copenhagen. World Health Organization, Palais Des Nations, Geneva, 1953. $3.00.

NEW AND NONOFFICIAL REMEDIES, 1953, Accepted by the Council on Pharmacy and Chemistry, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1953. Issued Under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. J. B. Lippincott Company, Philadelphia, London, Montreal.

MECHANISMS OF UROLOGIC DISEASE: By David M. Davis, M.D., Professor of Urology Emeritus, Jefferson Medical College; Visiting Lecturer in Urology, Graduate School of Medicine, University of Pennsylvania. 156 pages. Philadelphia and London: W. B. Saunders Company, 1953. Price $4.50.

EXPERIMENTAL ATHEROSCLEROSIS. By Louis N. Katz, M.D., Director, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Professorial Lecturer in Physiology, University of Chicago, Chicago, Illinois, and Jeremiah Stamler, M.D., Research Associate, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago, Illinois. Established Investigator, American Heart Association. Charles C. Thomas, Publisher, Springfield, Illinois, 1953. Price $10.50.

OPHTHALMOLOGIC DIAGNOSIS. By F. Herbert Haessler,

(*Continued on page 62*)

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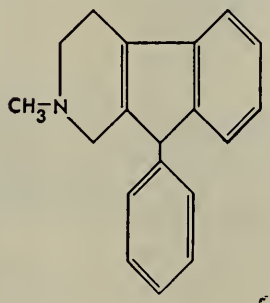
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*References on request

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BOOKS RECEIVED (Continued)

M.D., Professor and Director of the Division of Ophthalmology, Marquette University School of Medicine. The Williams & Wilkins Company, Baltimore, 1953. Price $8.00.

COPYING AND DUPLICATING MEDICAL SUBJECTS AND RADIOGRAPHS. By H. Lou Gibson, Technical Editor, Eastman Kodak Company, Rochester, New York. Charles C. Thomas, Publisher, Springfield, Illinois. Price $5.00.

PRACTICAL X-RAY TREATMENT. By Arthur W. Erskine, M.D., Fourth Edition, Revised and Enlarged. The Bruce Publishing Company, Saint Paul and Minneapolis, 1953. Price $5.00.

TEXTBOOK OF MEDICAL TREATMENT. By various authors. Edited by D. M. Dunlop, B.A. (Oxon.), M.D., F.R.C.P. (Ed.), F.R.C.P. (Lond.) L.S.P. Davidson, B.A. (Camb.), M.D., F.R.C.P. (Ed.), F.R.C.P. (Lond.), M.D. (Oslo) and Sir John McNee, D.S.O., M.D., D.Sc. (Glas), F.R.C.P. (Ed.), F.R.C.P. (Lond.) F.R.F.P.S. Sixth Edition. E. & S. Livingstone LTD., Edinburgh and London, 1953. Price $9.50.

REPORT OF THE MEDICAL RESEARCH COUNCIL FOR THE YEAR 1951-1952. Presented by the Lord President of the Council to Parliament by Command of Her Majesty, June 1953. Her Majesty's Stationery Office, London. Price $1.50.

STEDMAN'S MEDICAL DICTIONARY. Eighteenth Revised Edition, with Etymologic and Orthographic Rules. Edited by Norman Bruke Taylor, V.D., M.D., F.R.S.C., F.R.C.S. (Edin.) F.R.C.P. (Can.) M.R.C.S. (Lon.), University of Western Ontario and formerly of the University of Toronto, in collaboration with Lieut. Col. Allen Ellsworth Taylor, D.S.O., M.A., Classical Editor. The Williams & Wilkins Company, Baltimore, 1953. Price $11.50.

DISEASES OF THE DIGESTIVE SYSTEM. 57 contributors. Edited by Sidney A. Portis, B.S., M.D., F.A.C.P., Associate Clinical Professor of Medicine, University of Illinois Medical School; Senior Attending Physician, Department of Medicine, Michael Reese Hospital; Chief of Medical Services, Institute for Psychosomatic and Psychiatric Research and Training, Michael Reese Hospital, Chicago, Illinois. 3rd Edition. 1119 pages, 269 Illustrations, 5 plates in color. Lea & Febiger, Washington Square, Philadelphia 6, Pa. Price $20.00.

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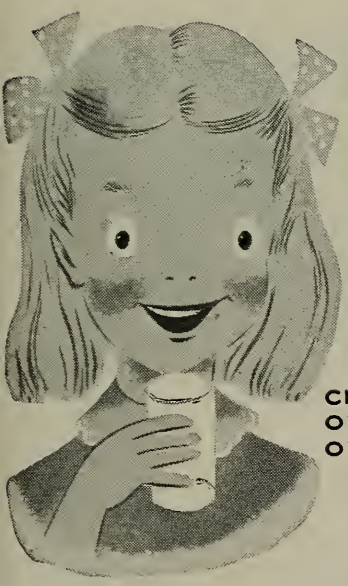
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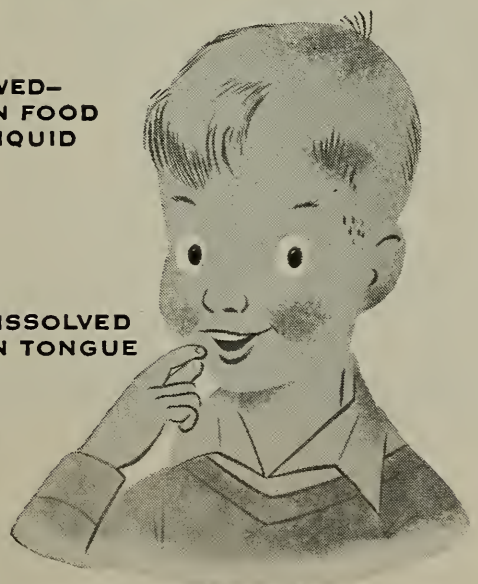
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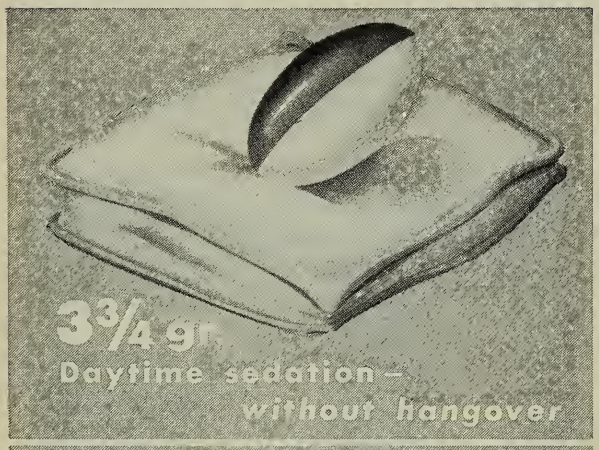
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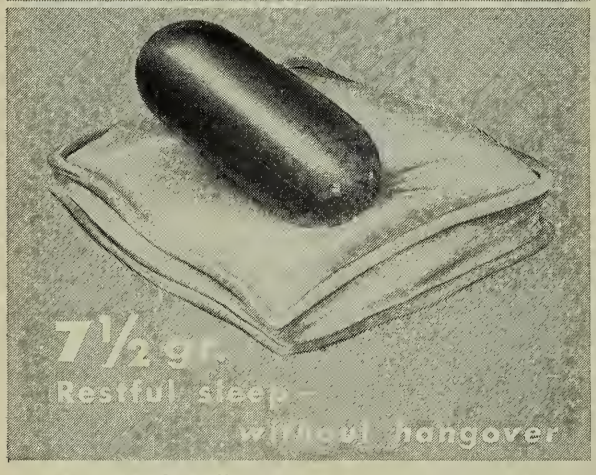
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KOREAN PHYSICIAN

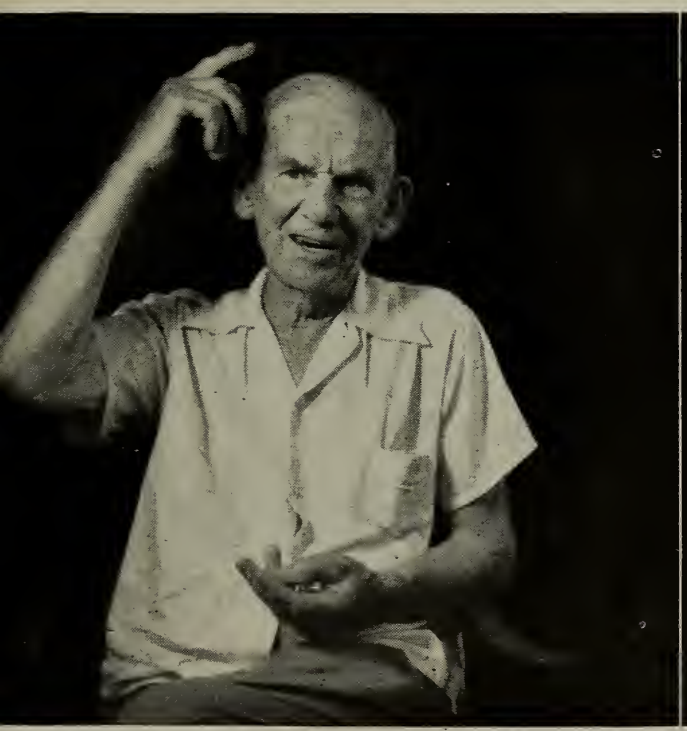
The death of Dr. Philip Jaisohn in Pennsylvania last year brings a fabulous life story to print in Medical Annals of the District of Columbia. It reads like both adventure and fiction. Dr. Jaisohn was born of a merger of two royal Korean families. He was a scholar by the age of 12 and as an adolescent he studied in the Japanese Military School. He became a liberal who eventually helped kidnap the Korean king in order to obtain social reforms. He fled with a price on his head, obtained an education in the United States with the help of friends. While acting as a translator for the Surgeon General's Library he became a friend of Drs. Billings, Gray, and Walter Reed, and was impelled by them to study medicine. He and Dr. Reed then attended the lectures of Dr. William (Pops) Welch at Hopkins. Dr. J. then became pathologist at Garfield Hospital in Washington. He also became an American citizen. Influential Koreans later persuaded him to return to his native land as adviser to the (new) emperor. He founded a club and a newspaper for independent thought, exposed corruption, fought destructive foreign interests, and attempted to improve the education and health of the people. He was called "The Father of his country" but the Japanese attempted to assassinate him. He returned to the States, and repeatedly pressed the case of Korea before the world. He returned to pathology in hospitals in Philadelphia, Chester, and Reading. He consulted on Korea in 1947-48, was president of their Red Cross, and refused the urging that he become president of Korea because he was an American. He was author of a book, was a Mason, a Rotarian, and recipient of numerous awards. His wife was a cousin of President James Buchanan. He lived 91 colorful, dangerous, helpful years. *Guillermo Osler, M. D., Topics Of Current Medical Interest. Arizona Med., March 1953.*

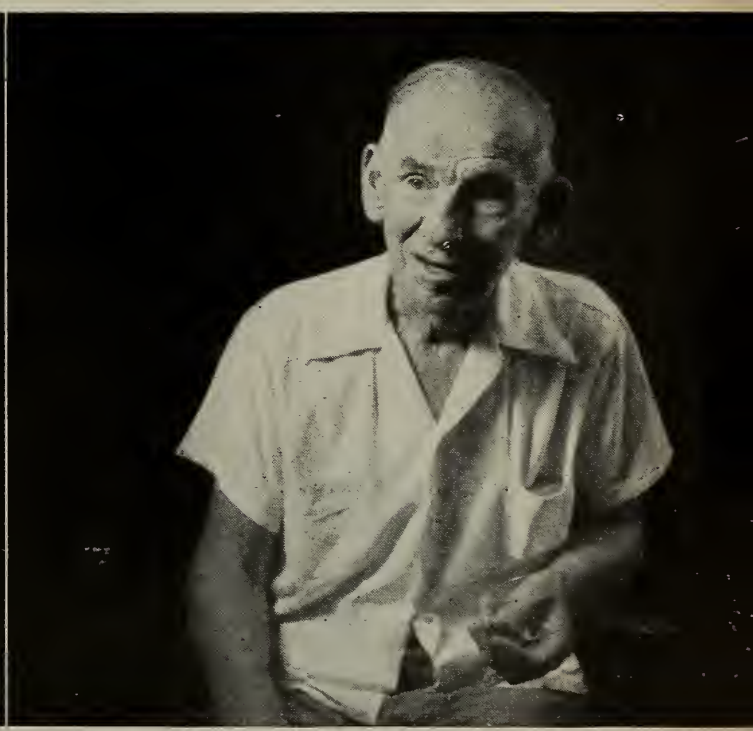
Mass chest X-ray surveys, originally intended to detect early pulmonary tuberculosis, have also revealed that other intrathoracic lesions may be found with some degree of frequency in apparently healthy people. Sidney E. Wolpaw, M.D., Annals of Internal Medicine, Sept. 1952.

Medical Treatment: For supportive therapy he was placed on 'Dexamyl'; one tablet every three hours from 7 A. M. to 4 P. M. "In three days it was reduced to q. 4 h., 7 A. M., 11 A. M. and 3 P. M. He was able to leave his bed after the third day." After 10 days the dosage was reduced to one tablet b.i.d. (7 A. M. and 1 P. M.).

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These unposed photographs of patient K.C. were snapped during an actual interview with his physician.





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DETECTION OF PREDISPOSED TO ATHEROSCLEROSIS

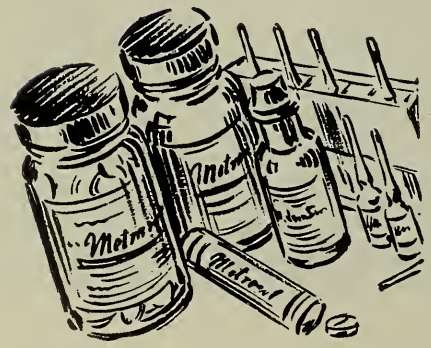
Our first effort is an elucidation of the findings which may indicate that the investigated individual is predisposed to degenerative disease processes. A carefully evaluated family and past history will offer an indication of such a predisposition. Heredity may involve a constitutional inadequacy of metabolism, indicated by familial gout, obesity, diabetes mellitus, hypothyroidism, coronary artery disease, and a host of other disorders associated with failure of metabolic processes. Hypertension may further accentuate susceptibility, especially during continued nervous and emotional tension. Much has been said of the somatotype susceptibility to disease and it may be true that a specific morphology, especially in relation to certain biochemical abnormalities, predisposes to degeneration. The social environment, economic status, and ambitions are important in the degree of stress to which an individual will be exposed. Economic and environmental elements should be considered during routine evaluations. These findings should be utilized for directing future activities. Industry, which carefully grooms talent for executive positions after intellectual consideration could with profit utilize these observations to determine a candidate's ability to withstand the stressful existence of the pre-executive stage. *Julius Pomeranze, M. D., Etiology And Treatment Of Atherosclerosis. Geriatrics, July 1953.*

Notwithstanding the reductions in tuberculosis mortality, there is a sizable task ahead before the disease may be considered completely under control. This task would be facilitated if some community in which the disease is still a major problem undertook a project to show how this could be done effectively under present conditions. The methods evolved should be capable of utilization widely, very much as the Framingham Demonstration set the pattern over 30 years ago. Louis I. Dublin, A 40 Year Campaign Against Tuberculosis, Metropolitan Life Insurance Company, 1952.

Klein referred to the report of the Medico-Legal Committee and noted with satisfaction that no cases were presented to the committee during the past year. He moved, seconded by F. H. Muller, that this portion of the report be approved. Motion carried.

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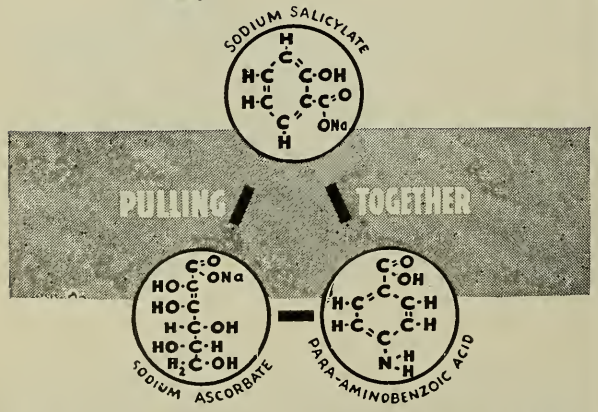
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UNETHICAL PHYSICIANS

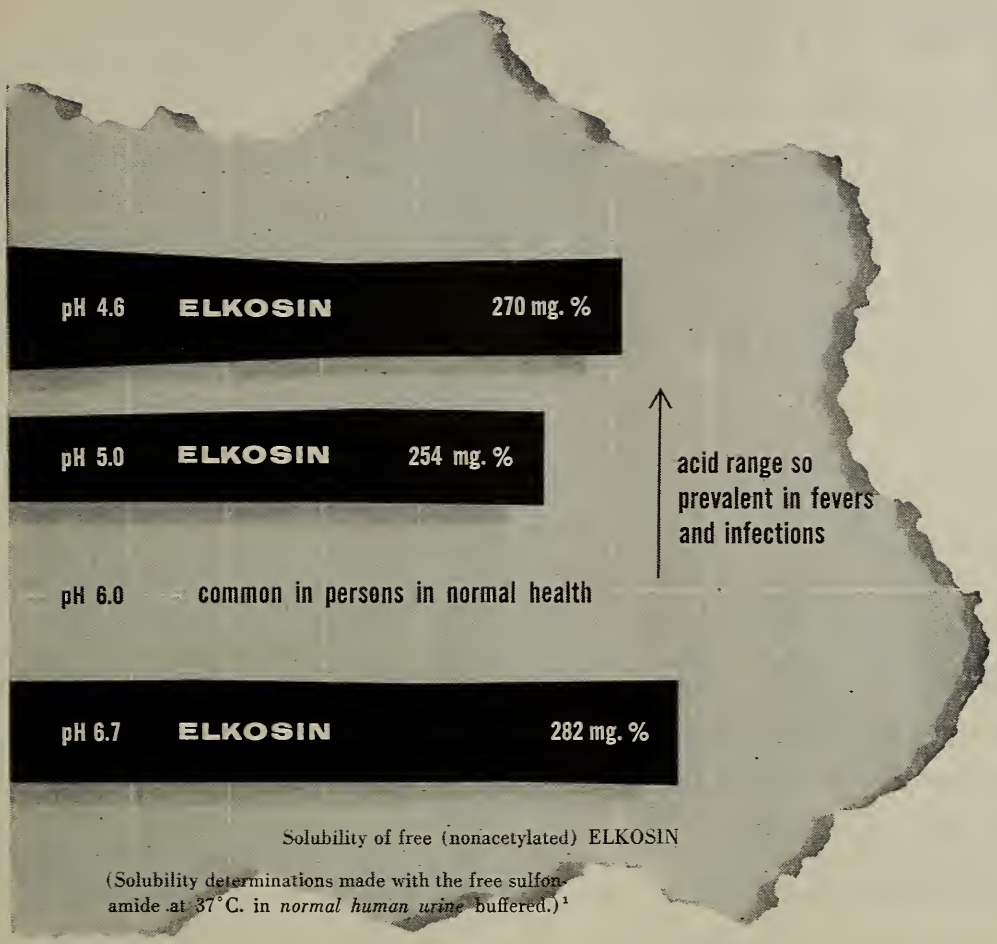
Two weeks ago an Associated Press story in the Chicago *Tribune* had this headline: "Charges Medics Steal Millions in Health Plan." The source of this story was an editorial in the Bulletin of the Los Angeles County Medical Society; comment also was carried in *Time* magazine.

The editorial stated: "Member physicians are robbing California Physicians Service and therefore themselves, of nearly one million dollars a year. In one doctor's case he made the obvious mistake of billing for surgery and subsequent office calls when the patient in question has actually been in New York during the period the services were allegedly performed."

The ironic fact is that while only 200 physician members out of 11,000 were participating in such fraudulent practices, the story was released without any disciplinary action to report. Thus the physicians not only in California but throughout the United States were condemned in a body on two counts — for permitting unethical practitioners to belong to organized medicine and second, for their failure to discipline those involved. However, at the present time, the California Medical Association and California Physician's Service are making a determined effort to prosecute those involved. *Leo O. Brown, Your Public Relations Is Showing. New York J. Med. Feb. 15, 1953.*

REHABILITATION BRINGS INDEPENDENCE

No normal person wants to be dependent upon others to feed and clothe him and move him from place to place. Every normal person wants to earn his own living. Most of the severely handicapped people we see can be trained to take care of their own daily needs completely; most of them can be trained to get from place to place; and many can be trained to be self-supporting. Aside from the human desire to enable these people to charge from dependent patients to self-confident individuals, we now have the urgent motive of shortage of man power in a time of crisis and financial uncertainty to urge us to enlarge the scope of our rehabilitation program. *C. A. Maxwell, M.D., The Contribution Of The Rehabilitation Center. Pub. Health News (New Jersey), March 1953.*



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1. Ziegler, J. B.; Bagdon, R. E., and Shabica, A. C.: To be published.

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THE SCHOOL VERSUS THE PRIVATE PHYSICIAN

Cooperation between the school health services and practicing private physicians must be the keystone if the school health program is to succeed and function effectively. The school health program must utilize fully the services of practicing physicians, without unnecessary duplication of effort. There must be mutual trust and respect and an awareness of the competency, skills, and contributions of both school physicians and practicing physicians. Both must be aware of their respective roles and functions, and their interdependence and relation to one another.

The family physician is the chief liaison officer in relation to the family and maintains continuity of care throughout the child's stay in school. He must, therefore, work very closely and harmoniously with the school health team to the best advantage of his little patients who are attending school.

It may be worth quoting one private physician's statement during an interview: "There is no competition between the school medical services and the private practice. I feel that the Department of Health is on the job when it sends to me as many children for examination and treatment as can afford it. Not only is it not in competition, but it is giving service necessary to the public welfare that cannot be given by private physicians."

Harold Jacobziner, M.D. and Robert Culbert, M.D., The Role And Function Of The Private Physician In The School Health Service Program. New York J. M. Jan. 1, 1953.

According to the National Office of Vital Statistics the trends of the past several years are continued in 1952: a substantial decline in tuberculosis mortality but a comparatively small decline in the number of newly reported cases. Public Health Reports, June, 1953.

The antituberculosis movement synthesized in one single crusade the efforts of sociologists, humanitarians, and hygienists to improve the fate of the destitute by social reforms; to strengthen the human body by advocating a healthy way of life; to control infection by tracking and destroying the tubercle bacilli. Rene J. Dubos, M.D., The American Review of TB, July, 1953.

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REST IN CORONARY THROMBOSIS

The recommendations of many outstanding clinicians to alter the long established principle of rest in the treatment of acute myocardial infarction should not be ignored or dismissed without consideration. The introduction of the idea of mobility into what may have been a static concept in rest therapy over a period of many years may prove to be of marked psychic and economic value. We have seen the period of rest reduced in the past few years from three months to a minimum of 2 to 3 weeks with no ill effect in some cases. It would be difficult to attribute any recurrence of occlusion to failure to take what might be termed "adequate rest". The introduction of this "new" idea in the therapy of an old disease brings sharply to our attention the necessity of detailed evaluation of the clinical severity of each case by all available diagnostic and clinical means. In this evaluation the personal experience of the examiner will play a significant role and may prove to be the critical fact that will determine the ultimate outcome of the disease by the selection of the optimal therapy. *Alphonse McMahon, M.D. The Coronary Problem. West Virginia M. J. January, 1953.*

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SENSATIONAL MEDICAL PUBLICITY

When doctors criticize the "sensationalism" of some of the medical reporting in newspapers and nonmedical magazines, they might do well to inquire who deserves the blame. Too often they point a scornful finger at an innocent agent. A case in point developed last April when newspapers carried a story about the value of estrogenic substances in treatment of coronary atherosclerosis. A typical newspaper story might have been as follows:

"Atlantic City, N.J., April 11 — An optimistic outlook in the treatment of hardening of the arteries with female sex hormones was presented this afternoon at the 26th Scientific Sessions of the American Heart Association at the Hotel Chelsea. Effective results in improving the condition of patients suffering from severe coronary disease by administering the female hormones, known as estrogens, were reviewed by Dr. David P. Barr, Professor of Medicine, Cornell University College and Physician-in-Chief of the New York Hospital. Dr. Barr said this recent development offers some encouragement that the development of atherosclerosis in man is not inevitable and that in the future it might be prevented or minimized by proper treatment. In delivering the George E. Brown Memorial Lecture, established in tribute to the late Mayo Clinic pioneer in the field of circulation, Dr. Barr stated: 'Atherosclerosis is responsible for more deaths and disability than any other human ailment. Man is unique among mammals in his predisposition to the disease, which in turn is shockingly prevalent.' Dr. Barr pointed out that it is believed the concentration and distribution of cholesterol and other fatty substances in the body may be important in causing atherosclerosis. However, he added, 'it has been found that lipid patterns in man are not immutable but can be modified to a considerable degree by hormonal influences.' "

This story stirred up a lot of interest because a great many adult males have coronary artery disease or fully expect to get it. Having read what was printed in the newspapers about Dr.

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Barr's lecture, they promptly began asking their doctors about this new treatment. Some of the doctors were not embarrassed by the inquiries because they had heard what Dr. Barr said and they knew he did not advocate administration of estrogenic substances for treatment of coronary artery disease. Most of them probably said something nasty about the tendency of newspaper reporters to build a sensational story out of basic scientific research. For the doctors who didn't hear Dr. Barr, patients' requests for the "new hormone treatment" may have been more than a little disturbing. Some of them were irritated by the implication that they were not abreast of latest therapeutic advances. Like their meeting-going colleagues, most of them probably ended by damning newspaper reporters, but a few may have taken it out on Dr. Barr. This editorial would not have been written if Dr. Barr, or newspapers, or newspaper reporters were to blame for the sensational twist of the typical story above. This story is reproduced, without embellishment or significant deletion, just as it appeared in a news release of the American Heart Association. We apologize for singling out the American Heart Association as an example for the origin of objectionable sensationalism. Certainly that association is not the sole offender nor is this an isolated instance. This kind of thing happens all the time and we have the uneasy feeling that when doctors are nettled by such sensationalism, other doctors are often to blame. *Editorial from GP, July 1953.*

Perhaps the most important factor in the incidence among hospital personnel is the undiagnosed case of tuberculosis. The only way to prevent contact with such sources is to discover these unsuspected cases earlier than seems possible in most general hospitals. It is suggested that the best means of offering this protection to medical personnel is to make routine chest films of every patient admitted to a hospital. William A. Abruzzi, Jr., M.D., and Rufus J. Hummel, M.D., The New Eng. J. of Med., April 23, 1953.

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SCHOOL HEALTH SERVICE

It is easy to develop a school health program for the program's sake or for our own sake, rather than for the sake of the children we are serving. Health officers and school administrators and an occasional teacher health coordinator may brag about "my health program." Communities which compete with each other in terms of which has the best health program in their school or their community, do it on the basis of the number of personnel employed, the number of pamphlets distributed, the number of physical examinations performed, the number of teeth filled, but rarely, if ever, in terms of the number of children who were directed into the paths of healthful living by the skillful ministrations of a teacher, a counsellor, a physician, a nurse, or possibly by the group working as a team. It is quite important that we have both the team work concept and the concept that what we are doing is not a school health program, per se, but a program for the improvement of a whole generation, collectively and individually. *Donald A. Dukelow, M.D. Serving The Child Effectively Through The School Health Program. J. Indiana M. A. January, 1953.*

SURGERY IN BRONCHIECTASIS

After bronchiectasis becomes irreversible there is no hope for a cure except by surgery. Until the development of a one stage lobectomy by Brunn in 1929, treatment was largely palliative. With the recent advances in thoracic surgery the operative procedure can be carried out with a very low mortality rate. The amount of pulmonary tissue removed depends on the amount of tissue involved in the process. Resections may involve segments of lobes, lobes or an entire lung. Obviously enough functioning pulmonary tissue must be present to allow normal activity before resection is considered. The risk of resection is slight compared to the risk of the patient keeping his diseased lung tissue. *Martin Leibovitz, M.D., Surgical Lesions Of The Chest In Children. J. Oklahoma M. A. March 1953.*

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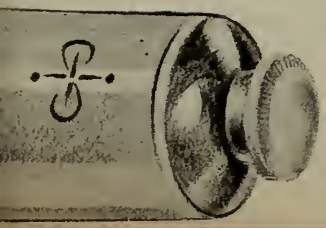
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STRICTURES OF ESOPHAGUS

Accidental swallowing of corrosive liquids is not infrequent in children. The most common offender is still lye. The most common site for stricture is at the lower one-third of the esophagus. On swallowing the lye, the sphincter at the cardia of the stomach goes into spasm and the lye is held in the lower end of the esophagus before passing on through to the stomach; during this period of retention a servere burn occurs. During the process of healing, the esophagus, particularly if it has had early and enthusiastic dilatations, will show severe cicatrix formation up to the point where the child will be unable to swallow soft or even liquid food. For adequate esophageal dilatation a gastrostomy is necessary and a standard procedure is to submit the child to periodic retrograde esophageal dilatation with bougies until a time at which it is felt that no further scarring and stenosis will take place. However, many times, stricture formation will occur many months or even years after the initial injury leading to continued difficulty which cannot be relieved by dilatations. Surgical therapy is now being undertaken in increasing numbers. The method most frequently used is resection of the strictured portion of the esophagus, mobilization of the stomach and re-establishment of the continuity of the gastrointestinal tract by esophagogastrostomy. *Martin Leibovitz, M.D. Surgical Lesions Of The Chest In Children. J. Oklahoma M. A. March 1953.*

FUNCTION OF DOCTOR'S WIFE

One of the principal functions of the doctor's wife is to make up for the deficiencies of her husband; if he is unsocial, she is social; if he has northern brusqueness, she cultivates southern urbanity; if he is strong and silent, she is pliable and eloquent. At the same time it must be admitted that just as Helen's excessive beauty launched a thousand ships, so the doctor's wife's excessive loyalty has wrecked a thousand partnerships. Dominating every question of the sexes is that one longer chromosome, which gives the woman a few extra genes, the persistent superiority or at any rate, greater potentiality of three per cent. A woman can afford to be generous and knows it. Most doctors' wives render great and unobtrusive service, if only by making a happy background without which their husbands could not function to the full. The doctor's wife shares with the parson's wife the advantage of being able to make of her job more or less what she likes. God bless her in the making. *C. G. Learoyd, M.R.C.P., L.R.C.P., The Doctor's Wife. Practitioner, June 1953.*

NUTRITION AND AGING

Experimental evidence is now at hand to indicate a close relationship between total quantity of food eaten and premature deterioration of the blood vessels. Insurance statistics prove conclusively the danger of overweight to longevity. Cancer, according to Stanley P. Reimann, is three times more common in obese than in those of more streamlined contour. The strain on body muscles and joints from overeating is generally recognized. Many individuals who are overweight are the victims of nutritional deficiency in one or more items esential to body health. A careful history and physical examination is all that is necessary to establish a diag- *ing And Nutritional Deficiencies. Pub. Health* nosis. *Edward L. Bortz, M.D., Premature Ag- News (New Jersey). March 1953.*

The incidence of tuberculosis is much higher among medical students than among similar groups of young adults in the general population. The primary complex is not necessarily benign. There is much evidence that it may directly precede progressive pulmonary tuberculosis or any complication, and therefore a re-evaluation of so-called minimal or benign disease seems necessary. William A. Abruzzi, Jr., M.D. and Rufus J. Hummel, M.D., The New England J. of Med., April 23, 1953.

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

Vol. 104, No. 4 October, 1953

Both Bone Fractures of the Leg. Principles of Treatment.

Carlo Scuderi, M. D.
Chicago

One of the most common fractures in the present mode of living is both-bone fracture of a leg. Once the fundamentals of treatment of these shaft fractures are understood, the various methods of treatment can be applied rationally.

Pathological Physiology

Figure 1 shows diagramatically an intact tibia and fibula with the large muscle bellies of the calf. The major muscles of this group have their origin in the femur and their insertion in the bones of the foot. So long as tibia and fibula remain intact, these muscles function without impairment and muscle tone remains uniformly normal. However, when firm fixation of the tibia and fibula are removed and pain is produced because of a both-bone fracture of the leg, these muscles are thrown into spasm and contraction becomes markedly intensified and prolonged over normal. The origin and insertion of these muscles tend to approximate one another because of muscle contractions and loss of bone stability as results in fractures illustrated in Figures 4, 5, 6, and 7. Shortening and displacement inevitably occur unless adequate treatment is rendered.

Solitary Fracture of the Fibula.

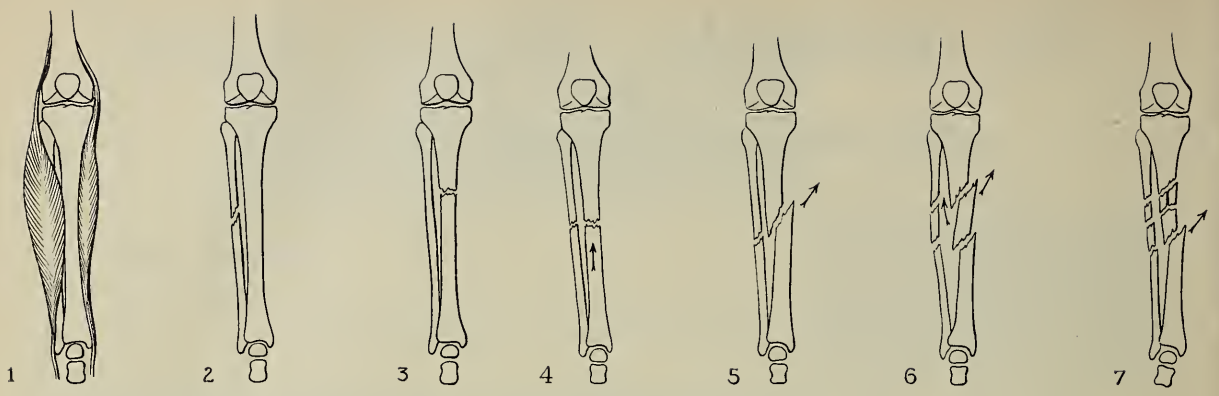
Occasionally the shaft or the fibula is fractured and the tibia remains intact. No shortening can occur, and displacement of the fibular fracture is minimal, if at all. (Figure 2).

This particular fracture can be successfully treated without any cast in cooperative adults. Avoidance of weight bearing by the use of crutches for five to six weeks usually is all that is necessary to attain a successful result. In children and uncooperative adults, the application of a cast from the lower third of the femur to the toes, reminds the patient that he is not to bear weight on the extremity. Should the patient become unruly, the cast will minimize any possible secondary trauma with resulting pain.

Solitary Fractures of the Tibia.

As the tibia is the main weight bearing bone of the lower leg, fractures of the tibia alone are of a greater magnitude than solitary fractures of the shaft of the fibula. (Figure 3). However, so long as the fibula remains intact, the tibia has an excellent internal splinting and no shortening can occur. Displacement of the bones at the fracture site may occur but it seldom would be great. Pain from this type of fracture is substantial and for this reason, immobilization in a cast is important. The cast should extend from the middle third of the femur to the toes. Unlimited weight bearing in this type of fracture is not advisable under four or five months in the average adult although many factors come into play and clinical judgment must govern the merits of each particular case. In children the period of healing is much more rapid in all fractures

Presented before the annual meeting of the Illinois State Medical Society, May 1952.



discussed and the period of immobilization should be shortened accordingly. In certain rare occasions where a severe local force has produced fracture, with complete displacement of the bone ends, open reduction with simple reapposition of the bone fragments may be necessary. Auto accidents usually cause this type of fracture.

Transverse Fractures of the Tibia and the Fibula.

Occasionally the tibia and fibula are broken at the same level, in a transverse direction. (Figure 4). The ends are jagged and are locked with one another so that it is difficult for this fracture to disengage itself. No shortening can occur and only angulation will result. For this reason, simple immobilization of the leg in a circular cast extending from mid-thigh to toes is all that is required. Any axial deviation can be corrected by secondary wedging of the cast.

Oblique Fractures of the Tibia and the Fibula.

In Figure 5, we see an oblique both-bone fracture of the tibia and fibula with overriding and displacement. In this type of case, it is impossible to successfully reduce and maintain reduction during the process of healing by the use of a simple cast. Muscle spasm and contracture inevitably will pull the fragments past one another. For this reason some form of therapy is required that will counteract or prevent shortening and displacement.

Skeletal traction will overcome shortening and frequently displacement, but this procedure requires a long hospital stay with the leg in traction until some evidence of beginning union takes place. This is somewhere in the vicinity of five to seven weeks. Double pin fixation with a Steinman pin through the proximal and one through the distal fragment, with reduction and immobilization in a circular cast, will work well if correctly used. Distraction of the fragments must be avoided. Once the correct alignment is attained, the patient can be up and about on crutches and can be discharged to his home and treated as an out-patient. The use of beaded wires incorporated in to a cast will maintain excellent reduction and fixation. In the hands of men experienced in this field, this method is most satisfactory. The use of multiple pin fixation of the fragments with external bar stabilization should be reserved for those cases where large skin defects prohibit the use of other plans. This method frequently leads to avoidable complications and is secondary to other methods of choice.

In a patient in relatively good health and with good skin, the author has felt that internal fixation by the use of two screws is most satisfactory. Immediate anatomical apposition can be attained and the use of a circular cast is then necessary until a solid bony union occurs. Because of the anatomical apposition and the firm fixation, this type of treatment produces a bony union in about one-third less than the length of time required by most other methods. Adequate equipment is necessary to reduce and maintain reduction during the operative procedure if sucess is to result. Improvised methods during the operation frequently are disastrous. The use of a constrictor and a fracture table are indispensable. This method has been used by the author whenever feasible for the last 18 years with a negligible number of complications or failures.

Both-Bone Fractures of the Tibia and Fibula with an Intermediary Third Fragment.

Figure 6 presents a complicated fracture be-

cause the intermediary fragment tends to get out of line and usually one or the other end goes on to a nonunion. For this reason early adequate reduction is necessary and can be successfully obtained only by open reduction and plating on the lateral side of the tibia. The T & G stainless steel plate lends itself readily to this type of fracture because it is long and can be overlapped one upon the other to give length and strength to the fixation. Intramedullary nailing of this type of fracture requires special equipment and experience and should not be attempted promisculously. Skeletal traction will serve to overcome shortening but does not assure proper alignment of the third fragment. In addition, distraction easily results, leading to nonunion.

Severely Comminuted Both-Bone Fractures of the Leg.

Figure 7 illustrates a severely comminuted both-bone fracture of the leg. Skeletal traction is indicated in this type of injury, otherwise shortening and angulation result. Double pin fixation with a cast also is a suitable treatment. Open reduction is contraindicated. It is axiomatic that "The more comminuted a fracture, the less is the indication for surgery." Any attempt at internal fixation in this type of fracture only adds to the existing problem. This type of case requires long immobilization and protection from weight bearing and frequently requires a bone graft for a delayed or nonunion.

CONCLUSIONS

1. Early adequate reduction and fixation is desirable in all cases.
2. The counteracting of the forces produced by muscle contractures must be understood and constantly kept in mind during the treatment.
3. Single fractures of the fibula or tibia, or transverse fractures of both bones of the leg can be successfully treated by casts alone.
4. Oblique both-bone fractures of the leg are best treated by open reduction and internal screw fixation. Double pin fixation or beaded wires also can be used with staisfactory results.
5. Intermediary third fragments of the tibia with displacement are best treated by internal plate fixation to prevent shortening and to lessen the incidence of nonunion.
6. Severely comminuted both-bone fractures of the leg are best treated by skeletal traction or double pin fixation.

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Would you say that the surgeons who performed these needless hysterectomies were competent? Would you grant that all those mistaken diagnoses were made by competent healers of the sick? Would you say that such criticisms made by members of your own profession create a picture of medical competence in general? *J. Lee Rogers, M.D., Could You Pass This Chiropractic Quiz? Medical Economics, July 1953.*

Preventive Psychiatry for the Physician

John M. Caldwell
Colonel, Medical Corps, USA

It is fairly self-evident that the practice of medicine is gradually undergoing a change. In the Spanish-American War, deaths from disease were at the rate of 34 per 1,000 men per annum. In World War I such a rate was 16.5, and during World War II the rate was 0.6. Operative surgery is becoming more and more restricted through the use of antibiotics and other measures. On the other hand, ill health because of emotional and personality problems seems to be relatively on the increase. It has been variously estimated that 30 to 50% or more of all patients who come to the physician have functional components as sole or complicating factors in their illness,[1, 2] and that the real incidence of neurotic illness is about equal to that of the common cold.[3]

The history of a disease usually begins with a description of its symptoms or indentifiable characteristics, thence progressing to a study of its physiology, pathology, the best methods of treatment, and finally to its prevention. Knowledge in psychiatry in the last 100 years has gradually advanced in each of these areas and today problems of prevention are of paramount importance.

We have been, perhaps, in the past, too prone to regard disease as affecting only an organ or an anatomical system, forgetting that the organ or system exists only as a part of the human biological unit, and that it is necessary to treat the human body as a whole. We have learned, too, that it isn't sufficient to treat the soma but that we must concomitantly treat the psyche as well.[4] Finally, we have learned that not only must we treat the psyche and soma but also consider the individual with reference to his social environment, his inter-personal relationships, the effect on him of external stresses and the need that he has for emotional supports. Disease and morbidity must therefore be looked upon as bio-psycho-socio-somatically determined.[5]

A mental conflict may be manifested as a neurosis, as a psychosis, as a psychosomatic disorder, as a personality or behavior problem. Even though mental conflicts have as a basis our earliest experiences, any specific disability is multi-determined, and effective treatment may be directed at various integrative levels and not necessarily at the original or basic etiology.[6] Thus successful psychological treatment may be directed at or limited to one or more psychological levels[7, 8] of integration. Too, treatment may be directed primarily at the soma through biochemical, physical or surgical means,[9] or treatment may be successfully directed at the elimination or modification of specific external stresses and the maintenance of emotional supports.[10]

Military Experience.— During World War II, from 1942-1945, the loss in manpower from neuropsychiatric causes was greater than that from any other single cause. Twelve percent of all those examined, or some 1,800,000 men, were rejected for military service because of neuropsychiatric reasons. In addition, at least 6 to 7% of total admissions to military hospitals, approximately 1,000,000 admissions, were of neuropsychiatric origin. Finally, 49% of all discharges for mental or physical defects, involving some 545,000 men, were for neuropsychiatric disorders. Included in those separated were 163,000 discharged through administrative (and not medical) channels because of intellectual or personality disorders. Lest these figures be considered alarming, it should be added that the numbers selected for service, hospitalized or discharged were, in part at least, due to changing personnel policies and the needs of the service, and were not always related to the seriousness of the neuropsychiatric disorder alone. Experience has shown that even individuals with long histories of chronic emotional instability, when placed in jobs within their competence and under suitable environmental conditions, do not break down but do reasonably good jobs.[11]

Outstanding among the factors related to an

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Presented before the General Assembly, 112th Annual Meeting, Illinois State Medical Society, Chicago, May 14, 1952.

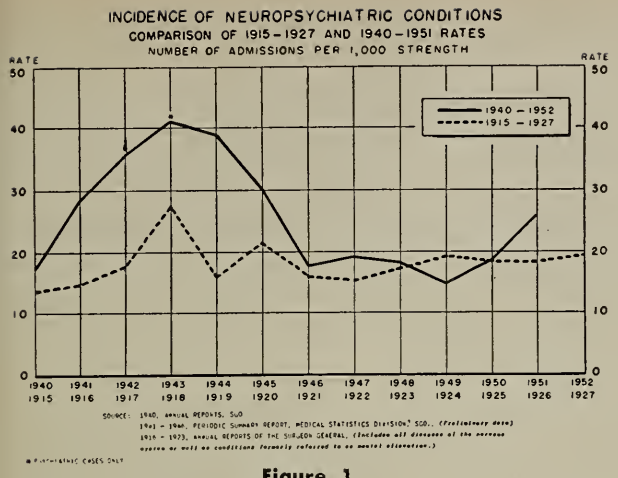


Figure 1

increased incidence of neuropsychiatric disorders is combat. Increases were to be found in World War I, in World War II, and after fighting began in Korea. With the cessation of active combat, the incidence of neuropsychiatric disorders decreased markedly. See Figure 1.

If the incidence rate of combat wounds is taken as an indicator of the stress of combat, it will be found that the incidence rate of psychiatric disorders is directly related to the incidence of combat wounded. This was found to be true in all theaters of war. See Figure 2.

At the beginning of World War II, the military services had not planned for large numbers of psychiatric casualties from combat. Men who broke down were evacuated to hospitals some distance in the rear and relatively few were returned to duty, and fewer still to combat duty. However, when psychiatrists were placed on duty with fighting divisions, and when treatment teams composed of psychiatrists were utilized near the front lines, from 70 to 90% of the psychiatric casualties were returned to effective duty — half or more of them to combat duty.

The incidence of psychiatric casualties in Korea has been comparable to the experiences in World War II, and is directly related to the stress of active combat.

However, the application of lessons learned in World War II has resulted in improved treatment to the extent that the number found necessary to be evacuated to the United States as unfit for duty in the Far East has been less than one-third of the number so evacuated from combat areas during World War II.

As a result of various medical and administrative policy changes, including emphasis on definitive treatment, discharges through medical channels for neuropsychiatric disorders currently are at a rate of only 1 to 2 per thousand men per year. This figure contrasts sharply with a rate of 24 in 1943, of 16 in 1945, and, in fact, is less than half of the discharge rate ordinarily to be expected during peace time. See Figure 3.

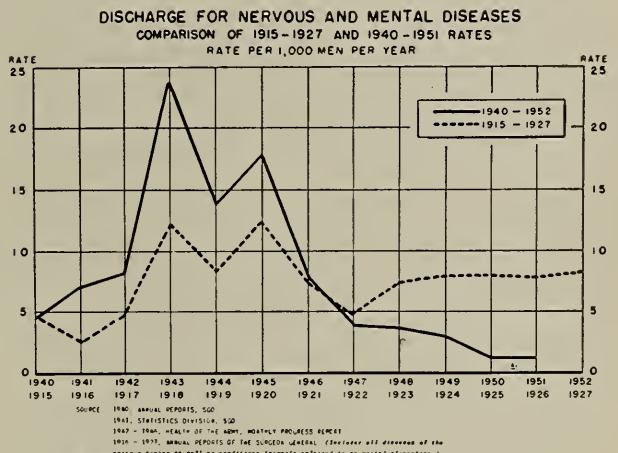


Figure 3

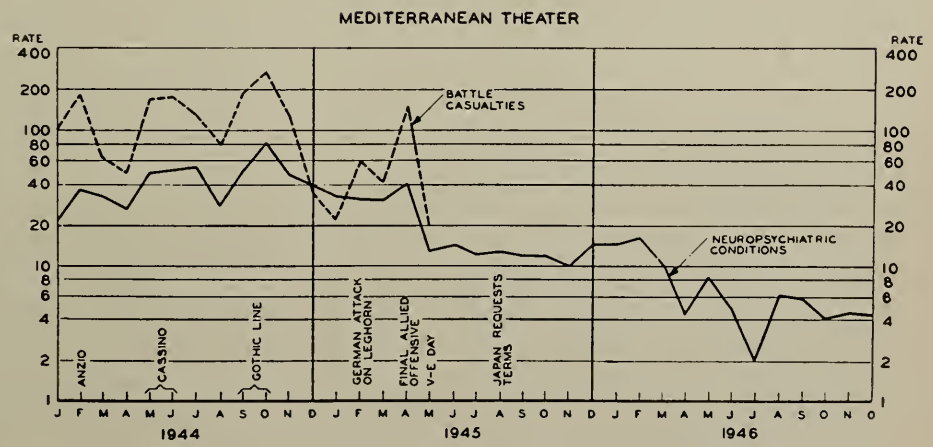


Figure 2

No matter how successful individual treatment may be, the number of available physicians, costs, time and even the welfare of the patient demand that every affort be made to prevent mental ill-health.

If we look upon health as mental, physical and social well-being, and not merely as the absence of disease, we might use, perhaps arbitrarily, some yardsticks to estimate the mental health of any given group. In the military service it has been found that certain rates in unit or commands reflect the efficiency status of that unit. The rates selected for comparison were the rates for absence without leave, venereal disease, sick call and courts martial. When such rates were high it was found that morale and efficiency in the unit was low, and if these rates were low then conversely the morale and efficiency could be expected to be high.

Field studies were made to find factors affecting these rates, either negatively as stresses operating, or positively as emotional supports. As stresses could be decreased or supports increased, so went the level of mental health or vice versa. Among the important stresses found were those of combat (discussed above), malassignment, certain training practices, the manner in which replacements were introduced to combat, the absence of or inequalities in combat rotation, and various personnel policies whenever such policies ignored or minimized the importance of the individual. Attitudes on the home front, including attitudes of loved ones, certainly had their effect on the mental health of individuals, if not of commands.

Among the especially important supports were the quality of leadership, the opportunity for group or unit identification, a positive motivation to do a job and the presence of incentives. Religious faith was a strong support for many, especially in combat areas.

Lessons From Military Experience For Civilian Application. — The lesson from military experience of the efficacy of early treatment in preventing prolonged disability has significance for every physician, particularly in methods of treatment, the detection of emotional complications in illness, the effect of the doctor-patient relationship, and methods of referral when help is needed.

Effective treatment requires every physician to be acquainted with the anatomy, physiology and pathology of the personality[12, 13, 14] and to be acquainted with the principles of psychiatric first aid — in a sense to be a front line psychiatrist.[15] The requirements for such treatment include the time and patience to listen, an attitude of sympathetic understanding, and the alertness to correlate significant situational factors or experiences with present and prior feelings, attitudes and repetitive patterns of illness or behavior.

The existence of an emotional factor in illness is frequently exemplified by the uncooperative patient who has procrastinated in seeking medical advice, who persists in self-diagnosis and self-treatment, and who sabotages treatment by ignoring diets, forgetting medications, breaking appointments, limiting treatment, or being hypersensitive to a personality study.[16] Sometimes emotional components are concealed in the unexpected or untoward result following a standard treatment procedure that has been proven to be efficacious in similar disorders.

It should not be forgotten either, in the doctor-patient relationship, that emotional disorders may be engendered by treating the patient simply as a case or as a disease, by over-treatment and encouraging attitudes of dependency, or by ill-advised statements by the physician in the patient's presence.[17]

When and if the need for more intensive treatment develops, a patient should not be referred to a psychiatrist without a clear and honest explanation in non-technical language of what the referral is all about, and something of what he, the patient, may expect.[18, 19] Expectations of rapid, miraculous cures should not be encouraged.

A broad approach to prevention of mental ill health, as that approch is practiced in the military service, may also be applicable to larger population groups. This approach would include establishing criteria for mental ill health and the identification of specific stresses and supports.

Rates that might be selected to measure the mental health or mental ill health of the population include rates of illness and morbidity, marriage, birth, divorce, suicide, accident, juvenile and adult delinquency, alcohol and drug addiction, unemployment, absenteeism. Current rates in these areas, taken as a whole, do not

indicate outstandingly good mental health for our population.

In contrast to a military population, where the age range is relatively narrow and the stresses perhaps comparatively limited in number, varying stresses operate in a civilian community on individuals from the cradle to the grave. Preventive psychiatry must consider the stresses affecting the infant, the child, the adolescent, the adult, and the elder or more mature members of our population. The problems of infant care, child health, parental attitudes, educational practices, sexual conflicts, marriage and divorce, economic difficulties, illness, occupational choice and adjustment, industrial practices, social customs, inter-personal relationships, retirement from jobs, group and international tensions must be studied and evaluated for an understanding of biologic and cultural factors that lead to a healthy emotional adjustment.

Obviously, psychiatry does not have the answers to all of these problems. Our knowledge is pitifully inadequate and much more study and research is needed before we can even be absolutely sure of even a small part of what we think we know. However, we can say that some of our knowledge and experience should be helpful in avoiding a repetition of errors in the past. And, on the basis of present knowledge there are some very definite suggestions that might be made.

Mental illness or ill health has been compared to a nutritional deficiency disease.[20] If certain individual needs are not supplied by the environment or by our culture, then the individual reacts in a maladjusted way. It has been said that the prime function of a leader or of a social order is to provide a dependable set of expectations.[21] Not only is the need for security one of our basic requirements, but the need to both give and receive affection, to be accepted and to have a place in the group, to be appreciated, to have a certain measure of freedom, and the opportunity to fulfill one's capabilities are all necessary ingredients of a healthy way of life.[22, 23]

An approach to some of the problems of infancy has been made by "The Cornelian Corner", wherein is advocated a much closer and more natural relationship between mother and child, with relief of tension incident to infant feeding, toilet training, and child discipline.[24, 25, 26, 27] There is quite a bit of helpful information about this very important period in our lives that is readily available.[28, 29, 30]

The problems of the juvenile period and adolescence are manifold and the period is filled with turbulence and violent emotional swings. Certainly parents have their problems in attempting wise guidance[31, 32, 33] and patient understanding of their children. Basic in this problem is the security of being loved by parents. After parents, teachers in our school systems probably have more influence on our development than any other group of people. The mental health of the teacher and her understanding of the problems of emotional adjustment of her pupils has a very vital influence on their development. It is not enough to have child guidance and school mental health clinics; detailed knowledge of the human personality and its structure should be matters of common knowledge.[34, 35] Not many of our schools have courses in social living in which students are taught how to understand and get along with each other, the problems of work, marriage, children and homes. Such knowledge is at least equal in importance to that of the three R's.

Of increasing importance is the growing knowledge of the "peer culture"[36]— that is, the relation of the adolescent to his contemporaries. The adolescent seeks to achieve status among his peers in one or more of his contemporary age groups. The patterns of behavior or attitudes adopted by the adolescent from his peer group may be such as to exclude entirely the influence of all adults. On the one hand, such close knit associations often serve to weather the difficult transition period from childhood to adult responsibilities, but on the other hand undesirable patterns of behavior may be thereby engendered.

As we move toward and into adulthood, problems of vocational choice,[37] marriage, individual competition, the necessity for success and the whole problem of adjusting to our environment becomes of paramount importance.[38, 39, 40] Certainly vocational guidance and counselling, pre-marital counselling, fully available community mental health clinics are all invaluable aids in assisting individual adjustment and cor-

recting maladjustment. In recent years there has been an increasing tendency towards centralized controls and absence of individual responsibility. Appel[41] states the problems succintly: "Too much control injures individuals, whether the child in the family or man in the State. It either creates too much dependency, with lack of initiative, inferiority, lack of productivity or dependability, or an inner resistance, rebellion, and sabotage of cooperation We hear a great deal these days of the Bill of Rights and the various Freedoms. But where is a Bill of Responsibilities and Duties? Rights cannot last unless people make a corresponding contribution of obligations and responsibilities, on which rights must be built and maintained."

Since we are an aging population, there is an ever-increasing segment of our population with special needs. I refer to the problems associated with early retirement from life-long jobs, the emotional problems of our more mature group or elderly people. Sudden change at any given age from an active participating kind of life to one in which the individual is regarded as having passed his usefulness is a severe emotional blow unless it is prepared for well in advance. To cease to be active is to begin to die, psychologically if not literally. To develop or acquire hobbies, avocations, and new interests beyond a primary vocation is not only to enjoy living to a greater degree but to provide an emotional cushion against the waning powers associated with advancing age.[42]

There are other important areas where psychiatric insights might be much more helpful than they are at present. One of these is in the area of juvenile and adult delinquency, including problems of crime, sex offenses, and alcoholism.[43, 44, 45, 46] Enlightened public attitudes on crime and punishment through the years have gradually brought about changes in the frequency of capital punishment, and the use of the dungeon. Now we have the prison and the reformatory, but we need institutions and clinics designed for mental treatment and rehabilitation of the delinquent. Custodial care and incarceration only as punishment have proved quite ineffective in restoring delinquents as useful members of society. A more extensive employment by courts of officially appointed expert psychiatrists to render an impartial opinion and assistance to the court would mark a distinct step forward.

Another area where psychological values are important is in industry and the employer-employee relationship.[47, 48] Absenteeism, accident proneness, employee turnover, and production are all related to morale and the prevailing emotional atmosphere. Attitudes are related to non-verbal behavior. Army units with good attitudes toward combat performed much more efficiently in battle than did units with poor attitudes.[49] Similarly, production records are best when management, foremen and supervisors devote time to human relationships rather than exclusively to production itself. Too, production levels increase as the group is given a voice in decisions; group pressures will set higher production levels than can be produced by order. Social competence is as important as is technical competence.

Another important area productive of tensions is the relation of majority to minority groups with bias and prejudice of one group towards another.[50, 51] Harsh attitudes arise in part from stereotypes or so-called universals in which one group regards another as characterized by so and so or such and such. The more that different groups are studied, regardless of race, creed or color, the better we realize that they are people like ourselves, with similar needs, desire and hopes.

There are many other areas that are worthy of profound attention in any program of preventive psychiatry. Among these are the supports that conceivably could be provided, such as a wise and kindly public leadership, a stable social order, a more inclusive group identification, a solidarity of group goals, education in the principles of mental health, and a re-examination of our system of values. Certainly part of our difficulties and perhaps part of the solution to our problem lies in the "intangible reality of conduct which resides in the ethical conscience of a people."[52]

It can readily be been that the job of preventive psychiatry is not the sole provice of psychiatry, nor even of medicine. The factors involved in the prevention of mental illness and the promotion of mental health involve the wholehearted and closest collaboration with social scientists, educators, clergy, civic and other

leaders, and even with each other merely as citizens.[53]

SUMMARY

1. Early specific treatment for mental illness has a preventive aspect in preventing more serious illness and prolonged disability.

2. On the basis of present knowledge, preventive psychiatry involves evaluation and modification of specific environmental stresses and the promotion of emotional supports as they exist from youth to old age.

3. The job of preventive psychiatry is not the sole province of psychiatry, nor even of medicine; it involves the collective experience of many scientific disciplines and assistance from leaders in all walks of life.

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Mediastinal Tumors

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With the rapid advance in thoracic surgery the diagnosis of mediastinal masses becomes increasingly more important. It is only in the last twenty years that definitive surgery of the mediastinum was attempted. Prior to that time, surgical exploration of the mediastinum was limited as a last resort to those cases where death was otherwise imminent. Today, with the development of modern surgical techniques, and improved anesthesia, the experienced surgeon enters the mediastinum with impunity. Outstanding advances in anesthesia has been one of the important factors contributing to the rapid progress in thoracic surgery in recent years. Such operations are usually long serious procedures calling for great skill on the part of the anesthetist in managing the resulting derangement of the delicate cardiopulmonary function for often long periods of time.

It is generally agreed that tumors of the mediastinum are more frequent than formerly believed. Yet they are not common as revealed by the fact that during the entire War II period only a total of 109 mediastinal tumors were reported by Blandes[1] from five army thoracic centers. The increased frequency of diagnosis of such tumors is undoubtedly due to the improved clinical examination which now almost always includes a chest x-ray. Mass roentgenographic surveys for detection of tuberculosis has contributed much toward uncovering silent mediastinal tumors.

We are in accord with Harrington[2] who states that all mediastinal tumors should be considered potentially malignant and this is substantiated by the statistics of Blades,[1] Laipply[3] and Harrington.[2] In his review of cases from five army thoracic centers, Blades' reports 15 malignant mediastinal tumors out of 109 explored. Harrington,[2] more recently, reported 33 malignant tumors out of 161 recoveries. Laipply[3] in his collected series of 288 cases of dermoid cysts and teratomas found 28 were malignant. It is important, therefore, that tumors of the mediastinum be recognized early and that treatment be instituted immediately before the growth has become maligant and metastasized or has caused serious and permanent injury from pressure to the vital structures within the thorax.

Benign tumors of the mediastinum frequently are present for months or years without producing symptoms and with the patient completely unaware of its presence. Such tumors may increase tremendously in size and produce symptoms by encroachment on vital structures. Thus pressure on adjacent structures as the bronchus, esophagus, vessels and nerves may produce such common symptoms as dyspnea, dysphagia, cough, hemoptysis and pain. Erosion into vital structures, such as major vascular channels may lead to sudden death.

Malignant tumors generally tend to manifest themseves while the tumor may still be quite small. Most of the symptoms occur as a result of invasion rather than by encroachment and early detection is extremely important if the patient's life is to be saved. Close cooperation between clinician and radiologist is a necessity to establish a high incidence of correct diagnoses. Gale and Curreri[4] point out that the presence of paralysis of the vocal cords or of a Horner's syndrome is considered indicative of a malignant process. The importance of utilizing such facts as the patient's age, clinical course, physical findings and response to clinical tests and therapy as invaluable aids in differential diagnosis is emphasized.

In reviewing the literature, it has been found that based on statistical studies certain types of tumors tend to occur in the same anatomical position in the mediastinum. The combined statistics of Blades,[1] Curreri,[4] Harrington[2] and Laipply[3] are found to be in general agreement. It is shown that 75% of the anterior mediastinal tumors are of dermoid or teratoid origin; 52% of the tumors in the central mediastinum are bronchogenic cysts; 90% of all posterior mediastinal tumors are neuroblastomas, and 95% of superior mediastinal tumors are either thyroid or thymomas. When one can accurately determine

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the anatomical position of the mediastinal mass, an important step has been gained in establishing a correct diagnosis.

Some knowledge of the relative incidence of the various types of mediastinal tumors that occur is a further diagnostic aid. In analyzing 268 reported cases, it was found that 75% of all mediastinal tumors are one of three main types, neuroblastomas (22%), cysts (63%), and teratoid tumors (15%). The remaining 25% were made up of connective tissue tumors, thymomas, vascular tumors, primary lymph node tumors, thyroid tumors, tuberculomas and hemartomas. Curreri and Gale[4] state flatly that by combining clinical and roentgenological findings it is possible to diagnose 80% of all mediastinal tumors.

The radiologist has an important responsibility in establishing a diagnosis of mediastinal tumors. It precludes a thorough knowledge of the four main anatomical divisions of the mediastinum and the structures contained therein. The size, shape, and location of the mass, its outline and confines are important to the radiologist. This requires the taking of films in postero-anterior, lateral and oblique projections. Fluoroscopy of the chest is invaluable in determining the presence of pulsating tumors such as aneurysms, the relationship of the tumor to deglutition, respiration, mediastinal shift and diaphragmatic motion. Stereoscopy is important in determining relationship of the tumor to adjacent structures. Finally bronchography should be used in ruling out tumors directly related to the bronchial tree.

Bronchoscopy and investigation of bronchial washings are important adjuncts to the diagnostic armamentarium. Not infrequently, pathological section of a peripheral lymph node will establish the cause for a mediastinal enlargement. Lymphomas and metastatic carcinomas are frequently detected in this way. The use of x-ray therapy as a diagnostic test to determine radiation sensitivity of the mass is a differential aid. Practically all lymphoblastomas with the possible exception of the reticulum cell sarcoma are radiosensitive and will show a remarkable regression after a short course of radiation therapy. We arbitrarily give six daily roentgen treatments of 200r each through anterior and posterior ports, (6 x 200r, in air, HVL-1.2 mm. cu.), and usually by the end of one month there is a marked regession of the mass. Benign tumors will show no such response and carcinomas may progress in spite of the irradiation. Cardiovascular opacification with high concentrations of radiopaque media will aid in identifying vascular lesions including thick walled aneurysms that do not pulsate. The use of radioactive iodine affords a means of verifying substernal extensions of the thyroid that must be differentiated from other mediastinal tumors.

Paul[5] places primary malignant tumors of the mediastinal nodes together and includes Hodgkin's disease, lymphosarcoma, lymphatic leukemia and aleukemic leukemia. Radiographically, Hodgkin's disease tends to involve individual groups of nodes more frequently than the entire mediastinum and localized nodular thickening is common. Lymphosarcoma tends to form large localized masses often unilateral or forms a broad mass across the mediastinum.

In the group of benign mediastinal tumors, the roentgen appearance is that of a single, sharply outlined round or oval mass. Paul[5] indicates the dermoid cyst as the most common lesion of this group. These form large well defined, smoothly rounded oval or lobulated masses in the anterior mediastinum. Calcification may occur in the wall and partially or completely formed teeth and irregular bone formation may be seen in over penetrated films. These findings are extremely helpful in diagnosis.

Bronchogenic carcinomas tend to form a unilateral mass that is usually quite dense and merges with the hilar shadow showing a fuzzy outer border. Paul[5] states unequivocally that in the presence of any unilateral mass in the region of the hilum of the lung, and especially if there is evidence of atelectasis, bronchogenic carcinoma should be suspected and further studies, especially bronchography, should be directed toward establishing its identity.

We believe that every effort should be made to identify a mediastinal mass preoperatively. If after all investigative methods have failed to establish the nature of the mass we advocate exploratory thoracotomy since it must be recognized that masses in the mediastinum are potentially dangerous to the patient's life. The cases presented in this report are examples of

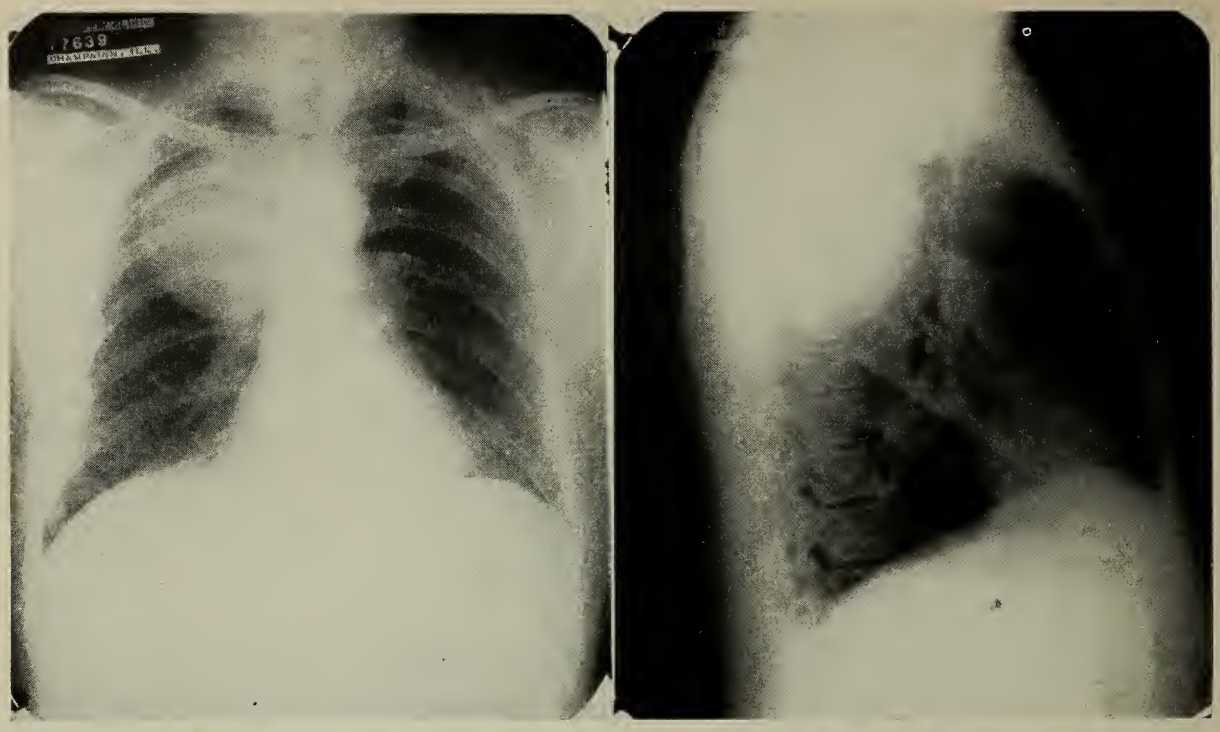


Figure 1. Chest film, postero-anterior and right lateral views. Well defined mass density occupying posterior mediastinum. Pathological diagnosis: Neurofibroma.

mediastinal masses most frequently encountered in clinical practice. Many of these were surgically amenable, others were not but are presented to show the important criteria in differential diagnosis. In general they illustrate the predominate type of tumor found in the four mediastinal divisions. One of the cases mentioned is an unusually large parathyroid adenoma in the mediastinum and is being reported separately.

Case 1.—E.T., a 43 year old white male first presented himself in the Clinic in November, 1947, because of a mass seen in the right side of his chest, found on a routine x-ray examination done at an Illinois State Fair. This patient was completely asymptomatic and physical examination was negative except for the evidence of a mass in the right chest.

Chest roentgenogram (Figure 1) revealed a well defined rounded mass density occupying the posterior mediastinum and measuring about ten centimeters in diameter. There was no evidence of erosion or invasion of adjacent bony structures.

The clinical impression was a mediastinal neurofibroma.

A right thoracotomy was performed (by J.M.C.) on December 4, 1947, through a posterolateral incision along the sixth rib, the greater part of which was excised subperiosteally. A large well circumscribed tumor was found lying in the posterior costovertebral sulcus and extending from upper edge of sixth rib at its attachment to vertebra to the level of the third rib. The tumor was extra-pleural in position though covered by tortuous vessels. It was easily mobilized and removed, the lung inflated and thorax closed. The patient made a rapid uneventful recovery. He is alive and well today.

The pathological diagnosis was a neurofibroma.

Case 2.—O.D.W. is a 55 year old white male who was first seen at the Clinic on February 23, 1948 stating that a large tumor mass was found in the right side of his chest in a routine chest film taken elsewhere. He had no symptoms referable to his chest and came to us because of his concern about the x-ray findings. His past history was not significant and physical examination revealed a healthy robust individual with no abnormal findings.

Chest roentgenogram (Figure 2) revealed a well circumscribed mass density lying within the anterior mediastinum and measuring 9 x 8 x 5 cms. in size. The density was of soft tissue character and contained no calcifications.

The clinical impression was a dermoisd cyst.

A right thoracotomy was done (by J.M.C.) on May 13, 1948 by subperiosteal excision of the posterolateral arc of the sixth rib. The tumor mass, found in the anterior mediastinum was well circumscribed, covered by pleura and attached to a broad pedicle to the sternum and pericardium. There was no evidence of invasion into adjacent structures and the mass was removed with relative ease. The lung was inflated and thorax closed. The patient made an uneventful recovery and remains alive and well today.

The pathological diagnosis was a fibroma.

Case 3.—C.R. is a 38 year old white female who



Figure 2. Chest film, postero-anterior and right lateral views. Well circumscribed mass density lying within the anterior mediastinum and showing no calcification. Pathological diagnosis: Fibroma.

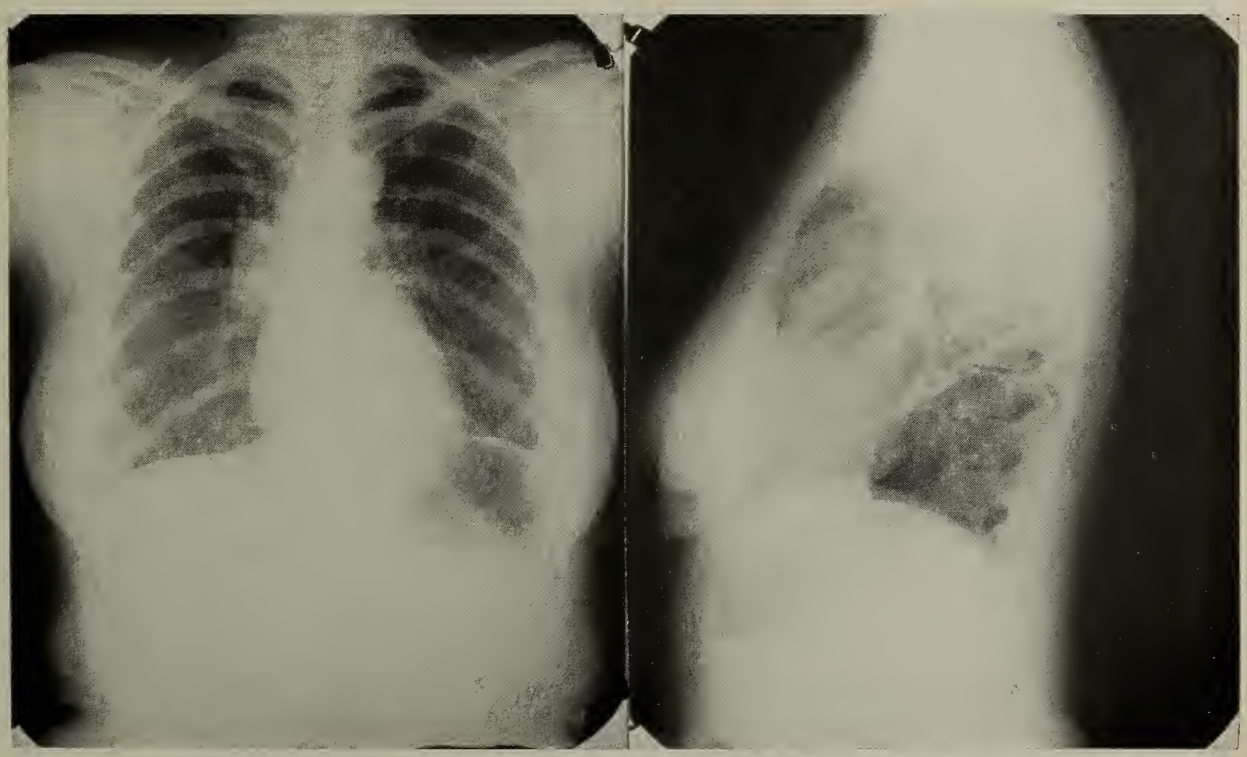


Figure 3. Chest film postero-anterior and right lateral views. Ovoid mass within the anterior mediastinum and containing plaques of calcium in its wall. Pathological diagnosis: Teratoma.

was aware of an abnormal mass in her chest for about six months previous to her primary examination at the Clinic on February 8, 1949. The mass was discovered incidently on a routine chest film. She experienced no symptoms and physical examination revealed no abnormality.

A chest film (Figure 3) showed an ovoid mass lying in the anterior mediastinum and containing plaques of calcium in its wall. Repeated films over a six month period showed no significant change in the size or shape of the mass.

The clinical impression was a teratoma.

Operative removal of this tumor was done by on of us (J.M.C.) on July 13, 1949 by subperiosteal excision of right fifth rib. This tumor though well encapsulated was densely adherent to the inferior vena cava, left innominate vein, descending aorta and pericardium. Sharp dissection was required and great care was necessary to avoid injury to the great vessels surrounding this growth. There was no gross invasion of other structures and after removal of the tumor, the lung was inflated and thorax closed. The patient made a rapid uncomplicated recovery and has since shown no sign of recurrence or metastases.

The pathological diagnosis was a teratoma.

Case 4.—L.E. is a 33 year old male who was in good health when first seen in the Clinic on September 8, 1949. The tumor mass was found on a routine film. He had no complaints relative to the tumor and physical examination was essentially negative.

The chest film (Figure 4) showed a moderate size mass density which was well delineated and lie in the central mediastinum at the level of the aortic arch. Fluoroscopic examination showed the aortic shadow to be intact and entirely separate from the mass. The mass showed no evidence of pulsation.

The clinical impression was a bronchogenic cyst.

This mass was removed surgically (by J.M.C.) September 14, 1949 through a posterolateral incision along the right sixth rib. The mass was relatively avascular and of cystic character. It was densely adherent to the right main bronchus from which it was freed by sharp and blunt dissection. Removal was complete and the bed of the tumor covered with pleura. This patient made an uneventful recovery and there has been no sign of recurrence of the lesion to date.

The pathological diagnosis was a bronchogenic cyst.

Case 5.—C. D. is a 50 year old male who first registered at the Clinic on November 1, 1949. His complaints were relative to his urinary tract, there being a history of previous removal of renal stones. The mediastinal mass was found on a routine chest film. He had no symptoms referable to his chest. He did complain of weakness and fatigue for the past month. A film of the abdomen showed large calculi in the renal areas, confirmed by pyelography. Salient laboratory findings showed the urine to contain many pus cells and bacteria with traces of albumin. Blood calcium was 9.8 mgms. and blood phosphorus 3.5 mgms. Sulkowitch test was normal. X-rays of the spine, pelvis and long bones showed generalized demineralization but little to suggest osteitis fibrosa cystica.

Chest film examination (Figure 5) showed a large well circumscribed mass in the right anterior mediastinum extending out to the lung parietes and measuring 16 cms. in diameter.

The clinical impression was a large benign tumor, probably a dermoid cyst.

On November 17, 1949, this tumor was resected by one of us (J.M.C.). It proved to be a solid fleshy tumor, encapsulated but adherent to pericardium, anterior chest wall and adjacent lung. After careful dissection the mass was completely removed, lung re-aerated and thorax closed. This patient is well today and shows no recurrence.

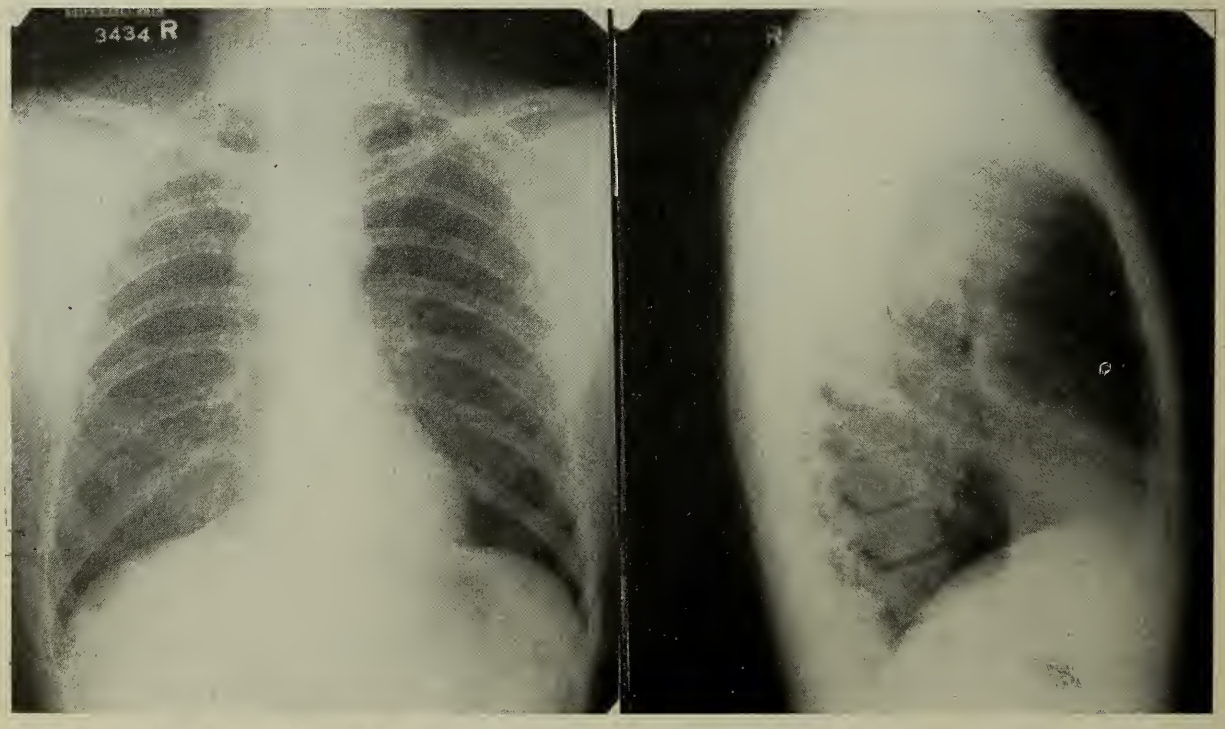


Figure 4. Chest film, postero-anterior and right lateral views. Moderate sized mass density within the central mediastinum at the level of the aortic arch. Fluoroscopically, the mass did not pulsate and was separate from the aorta. Pathological diagnosis: Bronchogenic cyst.

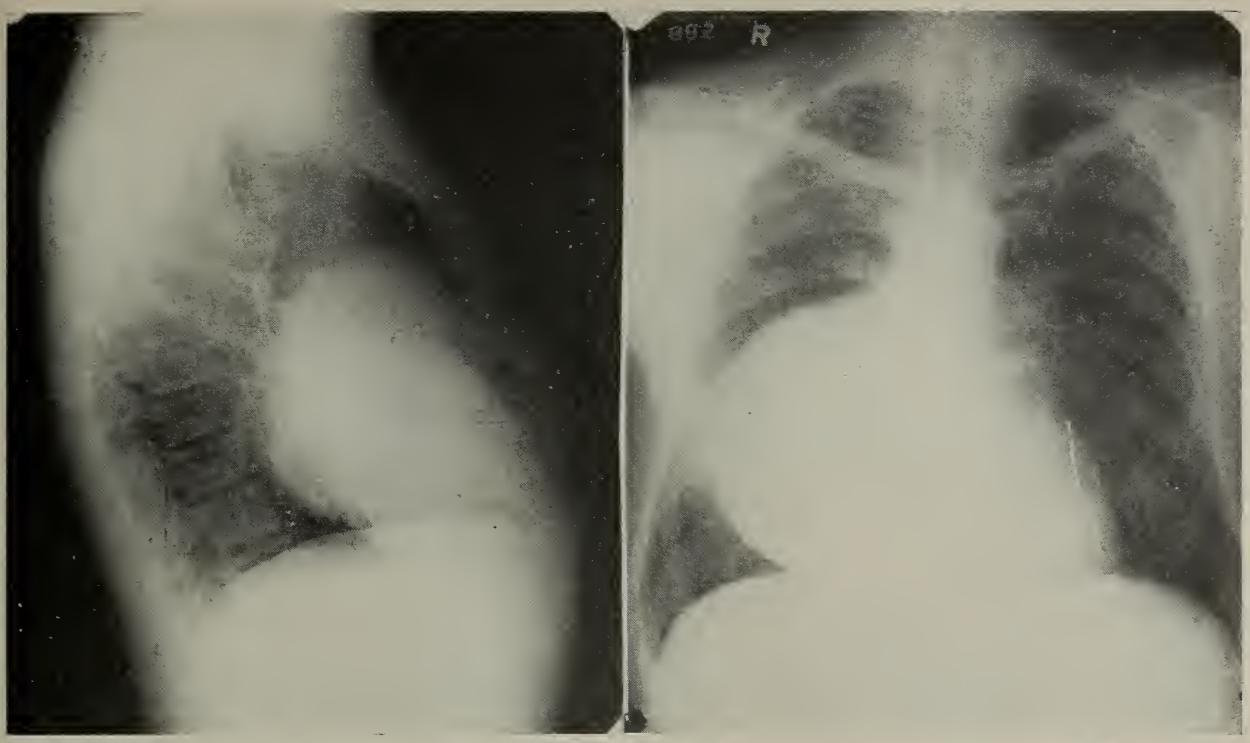


Figure 5. Chest film, postero-anterior and right lateral views. Large well circumscribed mass in right anterior mediastinum extending out to the lung parieties and measuring about 16 cms in diameter. Clinical impression: Dermoid cyst. Pathological diagnosis: Heterotopic parathyroid adenoma.

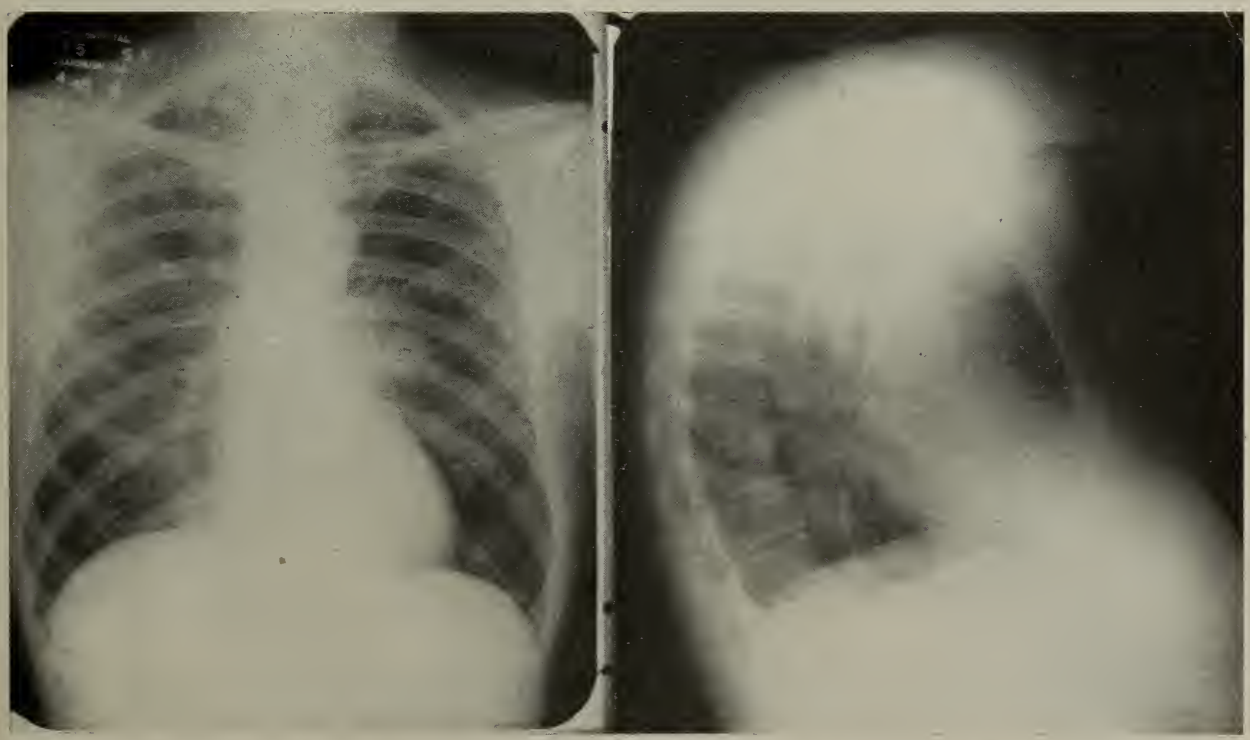


Figure 6. Chest film, postero-anterior and left lateral views. An abnormal mass density extending out of left lung hilum is seen having a fuzzy but nodular outer border. The mass is confined almost entirely to the hilar zone and an associated atelectasis is not present. Pathological diagnosis: Carcinoma simplex of the lung.



Figure 7. Chest film, postero-anterior and left lateral views. Diffuse enlargement of the aorta involving the arch and descending portions. Fluoroscopy confirmed the enlarged pulsating aortic shadow.

The pathological diagnosis was a heterotopic parathyroid adenoma. This diagnosis was confirmed by Edith Parkhill, Pathologist, Mayo Clinic.

Case 6.—F.C. is a 59 year old white male with a history of rather sudden appearance of clubbing of the fingers and toes associated with pain, tenderness, and some edema over the ankles. He had a persisting cough but no hemoptysis and no complaints relative to his chest. He had lost twelve pounds over a six week period. Physical examination was entirely negative.

A chest film (Figure 6) showed a mass density extending out of the left lung hilum and having a fuzzy but nodular outer border. The mass was confined almost entirely to the hilar zone. Progress films showed a slight increase in the size of the mass over a period of several weeks. Bronchoscopy and investigation of bronchial washings were negative.

The clinical impression was bronchogenic carcinoma.

On January 30, 1951 a left thoracotomy was done (by J.M.C.) and the tumor mass identified involving the left main stem bronchus close to the carina, There were no palpable metastatic mediastinal lymph nodes and a total left pneumonectomy afforded complete removal of the tumor.

The pathological diagnosis was carcinoma simplex of the lung.

Case 7.—O.D. was a 62 year old white female seen in the Clinic in October, 1949, because of recurrent headaches and dizziness. She had no particular complaints relative to her chest but had been aware of hypertension for many years. Her average blood pressure was 220 systolic and 110 diastolic.

A chest film (Figure 7) showed a remarkable diffuse enlargement of the aorta involving the arch and descending portions. The heart was enlarged chiefly to the left and due to left ventricular hypertrophy. Fluoroscopy confirmed the enlarged pulsating aortic shadow.

The clinical impression was a diffuse aortic aneurysm.

On April 12, 1950 this patient developed sudden marked dyspnea and died. Postmortem examination revealed a rupture of a diffuse aortic aneurysm.

Case 8.—M.E.P. is a 25 year old white female seen in the Clinic on October 18, 1949. She had recently moved to Champaign from the East and about two months previous gave birth to a normal fetus. About one week postpartum she began to run an elevated temperature and although delivery was normal the fever was attributed to postpartum infection. A course of penicillin therapy caused the temperature to drop to 99° but a normal temperature failed to occur.

A chest film (Figure 8) showed an extensive nodular mass involving the superior and anterior mediastinum. The mass density appeared to be enlarged right hilar lymph nodes with bilateral parathracheal lymph node enlargements as well.

The clinical impression was mediastinal lymphoblastoma, most likely Hodgkin's disease.

There were no available palpable peripheral lymph nodes at the time of the primary examination and a trial of roentgen therapy was advised. She received 6 x 200r to anterior and posterior mediastinum. There was a rapid decrease in the size of the mediastinal mass. This would confirm the lymphomatous nature

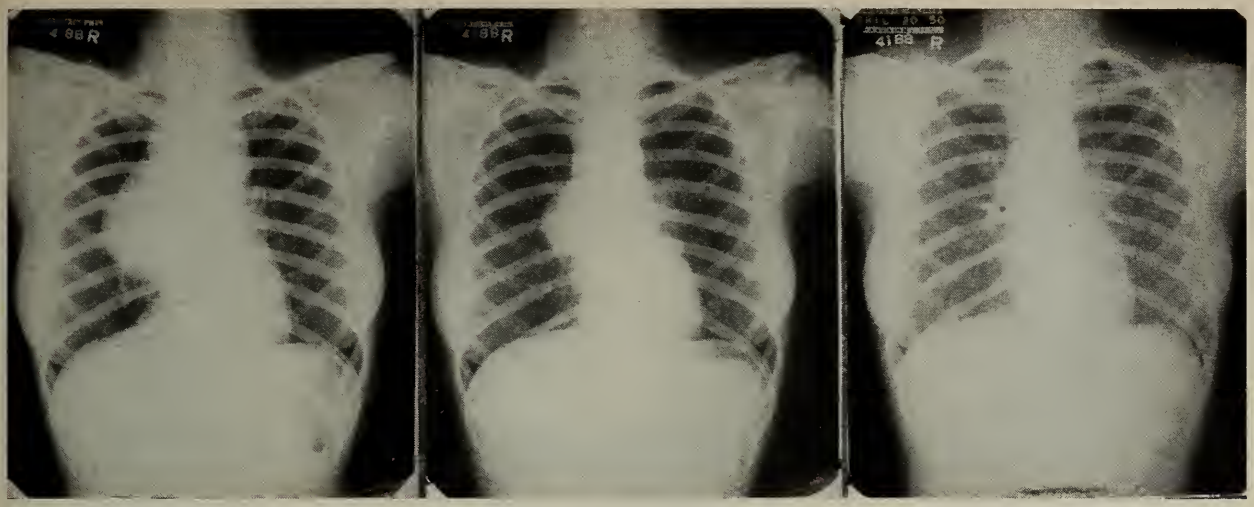


Figure 8. Serial chest films taken before x-ray therapy, one month and six months following irradiation. The rapid decrease in size of the abnormal mediastinal mass after x-ray treatment is evident. Pathological diagnosis; Hodgkins disease.

of the mass. On April 22, 1950 a small cervical lymph node was resected.

The patholigical diagnosis was Hodgkin's disease.

Case 9.—E.C.B. is a 50 year old female who was first seen at the Clinic on June 15, 1950 complaining of lower abdominal cramps associated with recent onset of amenorrhea. Her symptoms appeared to be menopausal in type but she had no chest complaints.

A chest film (Figure 9) showed a large mass lying in the left anterior mediastinum, extending from the left side of the heart to the lung parietes. It measured 16 cms. in diameter. Fluoroscopically, the mass failed to pulsate but could not be separated from the left cardiac border. A bucky film showed normal vascular markings through the mass with no evidence of atelectasis.

The clinical impression was a large benign tumor of left chest, most likely a pericardial cyst.

On August 1, 1950 a left thoracotomy was performed by one of us (J.M.C.) and the tumor mass identified. It was of cystic character and attached to the left heart wall close to the apex. The mass was removed by careful dissection, the lungs remaining intact and thorax closed. A speedy uneventful recovery ensued



Figure 9. Chest film, postero-anterior and left lateral views. Large mass density lying in the left anterior mediastinum and extending from the left side of the heart. Fluoroscopically, the mass failed to pulsate but could not be separated from the left cardiac border. Pathological diagnosis: Pericardial cyst.



Figure 10. Chest film, postero-anterior and left oblique views with barium swallow. A mass density is seen in the anterior and superior mediastinum. It encroaches on the tracheal shadow from the right and causes deflection of the esophagus as noted after barium swallow. Pathological diagnosis: Enlarged substernal thyroid.



Figure 11. Chest film, postero-anterior view. This film shows a large mass extending from the left hilar area. There are several rounded and smaller densities in the left upper and lower lobes. Clinical impression: Mediastinal and pulmonary metastases. Pathological diagnosis: Clear cell carcinoma.

and the patient is alive and well today.

The pathological diagnosis was a pericardial cyst.

Case 10.—K.S. is a 52 year old white male with typical symptoms of hyperthyroid disease, nervousness, weight loss, gross tremor, elevated basal metabolism, etc. A distinct enlargement of the thyroid, however, was not evident.

A chest film (Figure 10) showed a mass in the anterior and superior mediastinum. The mass produced an encroachment on the tracheal shadow from the right and on barium swallow a deflection of the esophagus.

The clinical impression was substernal extension of the thyroid gland.

On January 6, 1950 a subtotal thyroidectomy was done and the substernal position of thyroid was confirmed. Patient is living and showing marked improvement with most of the above symptoms no longer present.

Case 11.—W.P. was a 60 year old white female who was first in the Clinic in December, 1949. At that time, she complained of some dyspnea, weakness, weight loss, and an enlarging mass in the left side of her neck. The left cervical mass was firm and fixed and several smaller shotty nodes were present in the right supraclavicular area.

A chest film (Figure 11) showed a mass density extending from the left hilar area and several rounded parenchymal densities in the left upper and lower lobes. The clinical impression was mediastinal and pulmonary metastases, primary site not established.

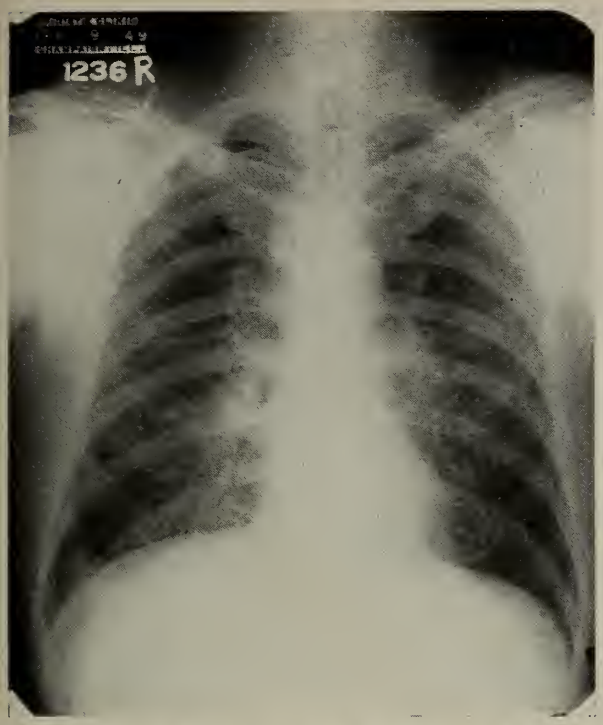


Figure 12. Chest film, postero-anterior view. This film shows a symmetrical bilaterial hilar adenopathy with some striations extending out into the lung fields. Clinical impression: Pulmonary sarcoidosis with a lymphoma not ruled out. Pathological diagnosis: Boeck's sarcoid.

On January 9, 1950 a biopsy of the mass in the left cervical area was done. The pathological diagnosis was clear cell carcinoma.

This patient received a course of palliative x-ray therapy to the mass in the neck and to the mediastinum. This caused a temporary decrease in the size of the masses but her course was soon rapidly downhill and on March 10, 1950 she expired. A postmortem examination was not done.

Case 12.—H.H.A. is a 47 year old white male first seen in the Clinic on March 18, 1949 with a history of a 15 pound weight loss, poor appetite, malaise, sore mouth and tongue, and vague gastro-intestinal complaints. Physical examination was generally negative.

A chest film on April 9, 1949 (Figure 12) showed bilateral hilar adenopathy with a good size right paratracheal lymph node. Some striations extended out into the peripheral lung fields.

The clinical impression was pulmonary sarcoidosis with a lymphoma to be ruled out.

This patient received a trial of x-ray therapy consisting of 6 x 200r through anterior and posterior mediastinal ports but showed no response. On April 23, 1949 an inguinal lymph node was removed.

The pathological diagnosis was Boeck's sarcoid.

This patient has been followed with periodic chest films and on December 28, 1950 the roentgenogram showed a significant clearing. He also has improved clinically.

Case 13.—R.S. is a 57 year old white male with a long history of regurgitating food several hours after eating. Recently, he lost about 15 pounds and was having a good deal of difficulty swallowing.

A chest film (Figure 13) showed a mass density in the superior mediastinum and on taking barium a good size diverticulum was identified in the upper third of the esophagus. This was a pulsion (Zenker's) type of diverticulum which was responsible for the mass density noted on the plain film examination.

On May 16, 1948, a thoracotomy was done, the diverticulum identified and completely resected. This patient made a complete recovery, has regained his normal weight, and there is disappearance of previous distressing symptoms.

SUMMARY AND CONCLUSIONS

It is our impression that early recognition of mediastinal masses and their eventual treatment must depend on close cooperation between the general practitioner whose attention may be first called to this abnormality by the patient, the radiologist and the surgeon. If each does his part a surprisingly high incidence of correct diagnoses may be established. This is confirmed by the experience of others as shown by a review of the literature herein presented.

The series of cases reported are examples of mediastinal masses encountered in everyday clinical practice. The methods of diagnosis and treatment of these are discussed. We par-

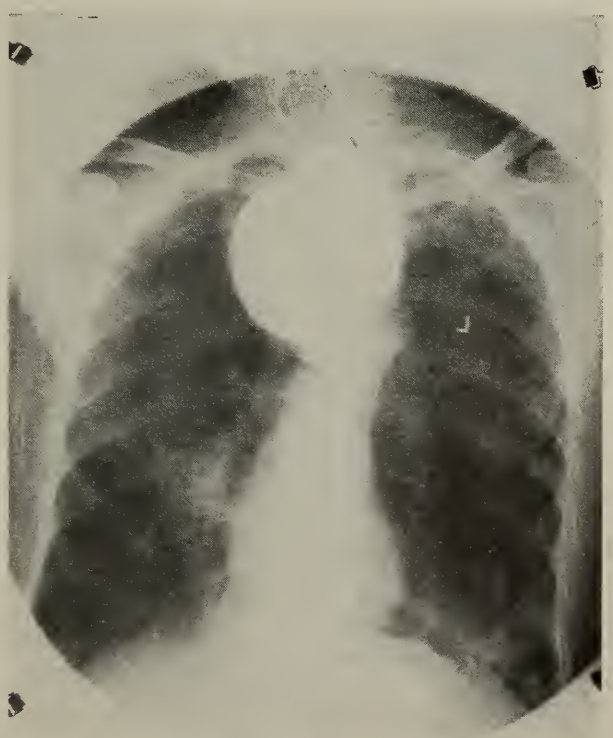


Figure 13. Chest film, postero-anterior view with barium swallow. This film shows a large esophageal diverticulum of pulsion type in the upper third of esophagus filled with barium. It accounts for the mass density in the superior mediastinum.

ticularly emphasize the need of doing an exploratory thoracotomy when all other procedures fail to establish the diagnosis.

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Public Relations

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I assume that most of us here have been so reared in the faith and the realities of a free America that even now, as a world war in ideas is disrupting established institutions everywhere, perhaps not one of us in his heart is ready to believe anything can happen to destroy the liberties that are our own heritage.

But of course, it can. Already, as we have stood by marveling with what ease world changes came to pass, one after another, the free governments have fallen. And now these United States stand as one of the few countries where the people still rule, where men may aspire to a better future and where the practice of medicine is still free.

Various reasons have been advanced for this amazing retreat from hard-won liberties, but the one important fact that need concern us is that the adherents of free government, those who support representative forms, the citizens — or, if you please, the customers of free government have been slipping away. They have been abandoning their basic charters. They have been turning to new doctrines, not from any considered knowledge that the new doctrines offer more, but for want of an understanding of their own government — its origins, purposes, methods and its results.

Now, when faith in an institution like government is lost — the purposes and principles forgotten — you must expect two results: the institution no longer renders its accustomed service and new leaders arise.

Precisely these things have been happening, not because of any inherent or chronic weakness in the governments concerned, but because free peoples have been too busy enjoying their benefits, too intent upon capitalizing their opportunities, ever to consider that the system which produced these benefits and opportunities might itself sometime be imperiled. Few have stopped to realize that one can live under and yet not understand the why and how of free government, can absorb its benefits, and still not know the fundamental features distinguishing it from other systems. Few have stopped to figure what loss to their own personal lives a change in the system might bring. Longtime familiarity with common rights and privileges so often breeds indifference — if not contempt.

Coincident with this decline in the spirit of free governments — and as a direct outgrowth — it has been only natural that some should question another inherently strong and important segment of our daily lives — I refer to the institution so firmly imbedded in American tradition, known as the practice of medicine — call it what you will, the facts are that our whole economic and medical system has been thrown into confusion. It has been thrown into confusion not because of any inherent or irremediable weakness within itself, but because it has failed to make clear to people the philosophy and principles of its own existence.

Address given before the Secretaries Conference, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.

If the American Medical System is to preserve the right to continue its contributions to the general welfare, under its present system, it must learn to interpret itself in deeds and in words that have meaning to others than itself. For it is not what medicine can do for itself that matters. Medicine's destiny rests and must necessarily rest not on the system's benefit to capital, not on its benefits to its members, but in the final analysis on its benefits to the most important group that is the common denominator of all — the consumer, the public, the group that outnumbers and includes all others.

We have been generally alert in building a medical system that has brought the American public the highest standard of health in the history of mankind. We have been inexcusably stupid in our failure to give them an understanding of how it is that the public's better health has become a reality under our present system of the practice of medicine. We have made too little effort to explain the A B C's — the simple premises and processes — of the American Medical System.

And until we get this elementary concept across how can we expect people to understand that their advanced standards of health — far higher than anywhere else in the world — are necessarily linked to the characteristic American principle of freedom under which the American system of medicine is forever striving to further improve the health of the people! Were this principle understood, people would have infinitely greater faith in their own security. They would see that hope ahead lies not in surrendering this basic formula but in making it work better and in making people understand it better. They would recall that less than a hundred years ago the average age at death was 38 and the health generally was poor, whereas today, the average age at death has risen to 68 and everyone has better health protection than that enjoyed by his forebears just fifty years ago.

Thrust by this turn in events into an awkward and unaccustomed place — conscious of our past omissions and critical future needs, medicine has been fervently taking stock of itself and submitting to the frank, and frequently brutal, self-examination. It is conducting a searching inquiry into the validity of its established principles and accepted doctrines. Out of this inquiry has come a great new interest in what we refer to as human, or public, relations as applied to medicine. For medicine, like democracy, depends for its present success and its future existence upon people, upon those who partake of its responsibilities and its benefits — upon men and women — upon the public.

One reason that medicine in the past, like business, has not needed to explain to the public advantages of the system, or that free government has not needed similarly to explain itself, is that in the earlier days these advantages were extolled in the literature of the time. The benefits were new and vivid. For most of the 177 years of our existence as a nation, our songs, our poetry, our school books, our popular literature were written in a vein reminding people that they lived in the best of all lands. Ambition was generally taught as an admirable trait. Successful men were objects of popular regard.

So, it is only in recent years that we have begun to talk about public relations. I wonder how many of us realize, when we use those words, exactly what they mean. I recall a quotation from Justice Holmes in one of his decisions when he said: "A word is not a crystal, transparent and unchanging; it is the skin of a living thought and may vary greatly in color and content according to the circumstances and time in which it is used."

Now when we put together two words which have not been together in the past — I mean the words public relations — we have joined two words that are not joined in Webster's Dictionary, although there you will find, public-house, public-service, public-school, and public-utility.

Public relations is a synthetic term carrying many meanings. By some it is used as a fancy name for common press agentry; by some as a term for insidious propaganda to put something over. By others it is used to mean the telling of the "favorable" side of business. It is, of course, none of these things. It is infinitely more — put the two words together in a different way and you have "relations with the public."

Now if we are going to talk about the public, we must regard the term as something more than a label. It refers to all the people — people comprising many overlapping groups. Public relations, therefore, is not something that can be applied to a particular phase of medicine —

nor is it an umbrella covering everything but touching nothing. It is rather a fundamental attitude of mind — a philosophy of practice — which deliberately and with enlightened selfishness places the broad interest of the patient first in every decision affecting the practice of medicine.

The philosophy of public relations turns not upon the needs of the profession but upon the needs of the people. And upon what better ground could medicine want to stand!

Let me go further and ask — upon what better basis can medicine go to the people and plead its franchise for continued service, so long as it offers through patient satisfaction a healthier, better way of living than has yet been developed through any other known system.

Defined broadly, good relations with the public is not something that medicine can achieve through publicity or through the activities of the American Medical Association, or the Illinois State Medical Society. Medical public relations is a continuous process by which the medical profession endeavors to earn the confidence and good will of the public — inwardly and by self-analysis and correction to the end that the best interests of the people will be served — outwardly by all means of expression so the public will understand and appreciate that their welfare is the profession's guiding principle.

We can all agree that this statement sounds mighty good, but it will remain a group of words and noble phrases unless we translate it into action. Only action will earn public approval and public support for our goals.

The medical profession needs good will and public understanding to obtain the private endowments and the funds from state legislatures to keep our medical schools at the highest levels of quality.

Public good will and understanding is needed to support our case against naturopaths, chiropractors and other pseudo medical cultists who would bring down the standards of the practice of medicine.

Public good will is needed to favor us in preventing hospitals from practicing medicine.

We need good will of the public to maintain their esteem of us as professional men, representing the most noble of the professions along with the ministry.

Public good will, will multiply our pleasure in the performance of our daily tasks and will endear us to our family and our friends. It is a blessing no less than the income which our fees bring.

Where do we get good will? Is good will something that can be bought like a stethoscope or a million units of penicillin? Can a medical society pass a resolution that "Resolved, from now on we will have more good will?" That would be about as effective as a law requiring water to run uphill. Because good will can't be demanded or resolved or bought. It's an effect. It's a result built over a long period of time by the acts of individual doctors and organized medicine, and how much the public knows about our good acts and how the public benefits by them. No — we can't buy good will. All of us have been around long enough to know that we seldom get something for nothing. Good will, too, we must earn.

Not everyone in medicine understands this constructive philosophy of public relations. And so, too many of our public relations efforts to date have been defensive measures. We have been engaged in putting out fires rather than removing the cause of trouble by building durably for the future. In some quarters the desperation of circumstances has encouraged a naive mixture of faith and hope that this thing called public relations would really turn out to be a new form of salvation, atoning for past sins and promising a blissful future. Dozens of press agents, straw vote experts and other specialists — good, bad and indifferent — have been drafted to perform that psychological face-lifting operation known as "molding public opinion." The result has ranged from the ludicrous to the tragic. But even so the result has been refreshing, for it has evidenced a groping for new standards. We are beginning to find that there is more to public relations than patching up the mistakes of the past or providing temporary and soothing substitutes for sound medical practices which should be in operation in every physician's office.

I think it must be apparent that the typical handling of public relations in the past will not measure up to the requirements of the future. I think it must be apparent that — as might be expected in a field so new — nowhere is there to

be found a public relations man who would claim to measure up to the requirements of today. We long ago passed the era of press agentry, but rare indeed is the organization or the man who has better than a child's grasp of what will be required through the broadened public relations approach of the years to come.

The problems which occupy a greater part of your time and attention today were scarcely heard of ten years ago. Conversely many of the problems which faced you a few years ago are rare today. In the field of medical practice, what has happened to the large scale epidemics, the severe illnesses that just a few years ago wiped out entire families and even entire communities? Medical science has conquered many of these, but new ones come to the front to take their place as our problems today in the practice of medicine.

The conquering of many of the fatal diseases of yesterday, the continuing medical research to conquer the diseases which face us today, are all proof of the validity of our system of free unregimented medicine. Such proofs are not monuments merely to be gazed at in wonder, or values only for future generations. They are benefits in use here and now by people, by men and women, by the public, who without these benefits would have been dead several years ago. Yet most of these men and women do not possess even a rudimentary knowledge of the source of these desired benefits of modern day medical science. Only a beginning effort has been made to explain why these benefits exist here and why they do not exist in many other countries of the world.

No truer statement was ever made than "public relations begins in the doctor's office." It is not the purpose of my discussion to delve into the public relations angles of the doctor-patient relationship.

It is you and the patient who are best able to decide if the diagnosis has been correct, if the operation has been successful, if the prescribed drugs, or appliances, or treatments have brought about a proper cure.

It is you and the patient who will know if the waiting periods in your office are too long, if the fees charged seem fair, or appear "unreasonable."

You and the patient will have to determine if your office is inviting, if your office employees are pleasant and courteous.

It will be the composite of your opinion and that of the patient whether or not an adequate personal interest is taken.

There are many other matters about the doctor-patient relationship likewise which you know far better than I do as to whether they create a favorable impression or an unfavorable impression.

Have we done all we can to make people understand these fundamentals? Have not you and I unwittingly allowed influences to seep into our land that will destroy our American practice of medicine unless we correct some public misconceptions soon? Have we not allowed concepts to grow up that are a threat not alone to the practice of medicine, but also to free enterprise — to government — and to the well being of the American public? Is it not a challenge to you and me as public relations men not to duck, but deal with the job of meeting these present day situations?

The challenge that faces us is to shake off our lethargy and through public relations make the American plan of medicine stick. For, unless the contributions of the system are explained to the public in terms of their own interests, the system itself will not stand against the storm of fallacies that rides the air in this era of easy, world-wide and instantaneous communication.

I refer to the fallacy that sets up class hatred by declaring that medicine is a device operating for the unholy benefit of the doctors.

I refer to the fallacy that the medical profession is curtailing the training of new physicians so as to maintain their high fees.

I refer to the fallacy that the way to make everyone healthy is to have the physicians and the health services of our country placed under the direction of government.

I refer to the fallacy that the great middle class cannot afford and cannot obtain proper medical care.

I refer to the fallacy that everyone can live an eternal life without worry, if we but permit government paternalism to take over in place of individual responsibility.

Now it is little comfort that these fallacies and theories, notions, contentions and beliefs have no basis in fact and that people ought to know better. Public relations must start not

with what people ought to think but with what they *actually* think. An opinion deeply rooted in public consciousness is just as much of a fact, so far as public relations is concerned, and just as important a fact to be dealt with, as a scientific finding from a research laboratory. And we must treat these psychological findings with all the respect we would treat any other finding. We must move up to them not in temper but objectively.

These fallacies present to the medical profession an honest challenge to interpret through public relations for public-guidance the principles and facts underlying the medical existence just as industry would if challenged in technical fields.

If American medicine, by constantly placing within the public's reach a better and healthier way of living, has helped to give the people of this nation the longest life in recorded history, and created the healthiest nation known to mankind, why should it hesitate to tell the story? Why should we not recognize our responsibility to clarify untruths, which if allowed to grow will destroy the present day practice of medicine and destroy for the public the benefits which are theirs?

Considering the stake, it is difficult to understand why the profession has allowed itself to be crowded through the smear techniques of the opposition into apologies for efforts to develop good relationships with the public. Nor is it easy to understand why we have sometimes been frightened into the notion that if we move, we must move with secrecy, with doubt of our approach — nor why we should not discuss openly and frankly everything we do in a desire to create good relationships with the public.

Now, how is medicine in its collective sense to go about this job? What the public thinks of medicine is the sum total of what it thinks of the individual physician. So the correction of past misconceptions and the foundations for future good concepts must boil up from the activities of the individual physician.

What is there that each individual society in its own sphere can do to possess the regards of people — do for itself as a component part of the system — it can clean up and bring to an end the misdeeds of a small group of our profession.

The most obvious lesson any physician can learn, and seemingly the most difficult, is that good relations outside grow from good relations inside. If there is any secret to success in building good public relations it is that you must begin at home and work from the inside out.

Lack of attention to grievances, real or fancied, inequalities in treatment, failure to listen to the patients' complaints, failure to explain the whys and wherefores — these are the things that underlie most troubles.

Good community relations grow largely from the attitude of your patients. As citizens of the community in which the physician practices, they are the best spokesmen for medicine. But beyond this, the physician, as a partaker of community benefits, must conscientiously assume his share of the community responsibilities.

The interest of the physician and the community are mutual and supplementary. Medical service through the doctor contributes to the security of the community's health — the community contributes to the livelihood of the physician. Unless the physician has confidence in the community and the community has confidence in the doctor, how can the interests of either be fully served?

With good relations in your office, and good relations within the community, you have the base for good relations with the public outside. But you can never take those relations for granted. We must know people, they must know us.

In conclusion let me say that none of these things are easy of attainment, but none of them are impossible of attainment. They will not be very difficult, as events seem to be shaping now — once medicine sets about solving its public relations problems with the same serious effort it set about solving its many baffling scientific problems in years gone by.

They will not be nearly so difficult to maintain as time goes on if we, mindful of our responsibilities, begin to stand "for" some things and not so often "against" things.

You and I and everyone working in the medical field must severely, and each in his own way, assign himself this task. We must look upon favorable public relations, not as something superimposed, but as the way of life. It is the philosophy of the Golden Rule, a constant

struggle to do unto others as you would have them do unto you.

What each individual physician does and says will vary. But there is one theme that must spread its way through every pattern, one basic formula all must follow. I refer to the paramount need for professional men, laboring men and all who live in this world today to plan their course mindful that jobs, fees, and pay checks come — first and last and all the time — from the customers — the public. I refer to the paramount need for all who are professional men or employers of labor to plan their course mindful that their existence is of the consumer, the public. With such a conception public relations will not go far wrong, for essentially are we not all customers — all public?

There is no place for public relations that connives or squirms or distorts facts. Public relations is honest. It is frank. It is open. It has vigor. It gains strength by application. Use it honestly, but use it by deeds and thoughts to make them multiply — without fear, without apology, without reserve. For to the extent that medicine through public relations fails to maintain its initiative, its courage, its freedom, is not the whole structure of our society endangered?

To establish this philosophy of concern for the patient as a basic concept of the profession, to see that it pervades the organization from top to bottom, to interpret with honesty the practices and precepts of the profession in terms of benefits to others — lest we lose for the world the right through sound and ceaseless progress to serve humanity — that as I see it is our job. That is public relations.

Clinical Evaluation of a New Antitussive Agent

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Chicago

Cough is a protective and beneficial reflex, but when the symptom is severe, frequent, or prolonged it may be harmful as it deprives a patient of much needed physical and mental rest. The latter type of coughing inflicts a heavy burden upon the respiratory apparatus. The work required of the lungs during a period of persistent coughing is often more strenuous than that from walking or running a long distance. The expulsion force against a closed glottis increases intrapulmonary pressure, produces changes as found in emphysema, and may cause hemoptysis and expansion of cavities.

Judicious therapy for control of cough is indicated. Dry, unproductive cough should be made productive, if possible, by the administration of proper expectorants. Otherwise it should be suppressed. Productive cough eliminates secretions and may avert intrabronchial spread and progressive infection. This cough should be relieved, but without interference with expectoration.

The commonly used anodyne antitussives, codeine and morphine, not only depress the cough reflex, but other reflexes as well. These drugs slow down the ciliary action of the bronchi and may prevent elimination of mucus, sputum, blood, and foreign material. These compounds also cause constipation, drowsiness, sleep, and habituation.

A new substance, dihydrocodeinone bitartrate (Hycodan®bitartrate), is now available for symptomatic relief or cough. This codeine

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derivative has been reported to be more effective than codeine and to possess a low incidence of side reactions (1,2,3,4,5). Hence we thought it desirable to determine its therapeutic value in tuberculous patients.

Since no specific criteria for the clinical evaluation of cough relieving drugs were known to us, it was decided to seek information on the following effects: (1) Time interval between administration and onset of action; (2) duration of effect; (3) interference with expectoration; (4) interruption of sleep by cough; (5) side effects such as drowsiness, nausea, constipation, and depression of respiration and heart rate; (6) and habit forming properties.

In the early stages of tuberculosis, cough may respond to almost any therapy and frequently can be managed without drugs. For our purpose we, therefore, selected patients who had advanced tuberculosis. Cough in all was difficult to control, exhausting, and interfered with sleep and rest.

Reports from patients on therapeutic results often are unreliable. This applies particularly to tuberculous patients because these individuals are easily influenced and inclined to accept new medications and treatments favorably. The drug was dispensed in syrup licorice, a vehicle that had been used previously for other cough relieving compounds, so that there was no change in appearance, taste or color of the cough mixture. Persons in charge of dispensing were cautioned not to let the patients know that a new drug was being administered. To insure uniform evaluation of results, only two persons were charged with observation and interpretation of the effects. They were briefed in minute details on the nature and purpose of this study.

Suppression of cough at night so that patients may sleep is one of the most desirable actions of a satisfactory antitussive. This effect presents an objective criterion for the evaluation of such drugs. Every interruption of sleep by cough was noted and reported. Patients were considered to be under effective therapeutic control when they slept at night without interruption by cough. When benefit was derived but occasional coughing called for an additional dose the result was classified as "partial relief".

First a pilot study was carried out. Seventeen patients were given one dram of syrup licorice three times daily, each dram containing 5 mgm. (1/12 gr.) of Hycodan®. This medication was maintained for one week. Ten of the patients obtained complete relief of cough with this dose. For the other seven, the third and last daily dose was increased to two drams of the mixture. With this increased dosage the cough of three was alleviated.

The remaining four patients then received three daily does of 10 mgm. (1/6 gr.) of Hycodan®. Two of these persons were relieved on this schedule. The last two patients [far advanced cases and severe coughers] were then given two drams of the mixture (10 mgm. or 1/6 gr.) three times daily and one dram (5 mgm. or 1/12 gr.) as needed. This provided relief for one.

From this preliminary study it was concluded that two drams of the mixture might be an effective therapeutic dose which if administered three times daily would afford adequate relief of cough in the majority.

Treatment of a selected group of 44 patients was thereupon initiated, 12 males and 32 females, varying in age from 16 to 65. Of these 17 were moderate and 27 far advanced cases of pulmonary tuberculosis.

Table 1
Age groups of 44 Patients who Received Hycodan

Age group	Number of patients
Under 20	3
20-29	9
30-39	9
40-49	11
50-59	7
60 and over	5
	Total 44

Each patient was given two drams of syrup licorice containing 1/6 gr. (10 mgm.) three times a day. Table 2 shows results of use of Hycodan. In most cases cough was controlled adequately. In some instances, however, the duration of effect was insufficient and a fourth dose was required to keep cough under control. Three of the 44 patients had to be given more of the mixture at night as needed.

The medication was used for varying periods the minimum duration being seven days; the maximum 30 days.

TABLE 2
Results of Use of Hycodan

Number of days	Total	Number of patients Relieved of cough	Partially relieved	Not relieved
7	15	9	5	1
21	12	8	3	1
30	17	13	3	1
Total	44(100%)	30(68%)	11(25%)	3(7%)

The three patients not helped were far advanced cases of pulmonary tuberculosis.

Fast onset of relief was observed. Soon after administration of the first dose coughing began to diminish in intensity and the interval between spells became longer. The majority were relieved effectively for five hours or more.

Although the drug decreased the frequency of cough, it did not suppress it completely. When abundant secretion reached the irritable level in the air passages patients usually coughed and had no difficulty in expelling mucus and exudate. Upon questioning, none of the patients reported chest tightness or throat dryness which are common complaints when cough depressants are used. Night cough sedation was provided in the majority of patients. They slept well and appeared rested in the morning. Those who were awakened by cough, benefited by reduced frequency and intensity of their cough. No increased dyspnea was seen nor were any signs of added induced constipation found in the group of 44 patients. There were no complaints of nausea, drowsiness, or dizziness. Our dosage did not depress the heart rate.

When the drug was discontinued there was no indication of addiction or withdrawal symptoms. It should be kept in mind, however, that the maximum duration of treatment was 30 days, a period which may be too short to determine the habit forming potentialities of this drug.

SUMMARY

A codeine derivative, Hycodan®, has been clinically tested for relief of cough according to specified criteria.

The optimum dose was established in a pilot study.

Results indicate it is an effective and satisfactory antitussive agent, which relieves cough without interference with expectoration and without other apparent undesirable side reactions.

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The principal needs (in tuberculosis control) can be simply stated: more hospital facilities, not only to cure but to isolate open cases from spreading further infection; more preventive work; better education in tuberculosis for the oncoming generation of medical students and nurses; and more education of the lay public regarding the prevention and care of tuberculosis, that is, health education. These objectives need no confusing elaboration. Alan Gregg, M.D., Am. Rev. Tuberc., April, 1953.

A tourist spending the night in a small Vermont town joined several men sitting on the porch of the general store. They were a taciturn bunch and, after several vain attempts to start a conversation, he finally asked, "Is there a law against talking in this town?"

"No law against it," answered one of the men, "but there's an understanding no one's to speak unless he's sure he can improve on silence."

Social and Psychological Factors in the Breakdown of Displaced Persons

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This paper concerns some psychotic displaced persons, D.P.'s who left their home countries during the last few years, could not or refused to return there and arrived finally in the United States. Since 1945 their number amounts to several hundred thousand. The terms immigrant, refugee and D.P. partly overlap, although they are not entirely identical. Maurice R. Davie of Yale University edited a book in 1946 called *Refugees in America,*[5] in which he compares the older immigrants to the United States until 1933 with the group who came here from 1933 until 1944. This second group, especially those who came from Europe, consists mainly of refugees. There are certain differences between these two groups. The older group of immigrants came to the United States mainly for financial reasons and consisted of a large number of different nationalities. The predominating nationality groups changed several times. Most of them were men from the working class, presenting economic competition to the lower income group of the population of this country. They consisted largely of unskilled workers. The immigration acts of 1917 and 1924 curbed immigration with the quota system. Only 2% of each nationality group, on the basis of the U.S. census of 1890, were allowed to immigrate yearly from then on. Since the west European countries had high quotas and the eastern Europeans relatively low ones, and the new immigrants consisted mainly of eastern Europeans, after 1924 no more than 17% of the legally permitted 150,000 immigrants came to this country yearly.

The next group of immigrants, largely consisting of refugees, entered this country between 1924 and 1933. In those twelve years of the Nazi era in Europe the Jewish newcomers constituted the largest group, amounting to about 50% of all immigrants and about 2/3 of the European immigrants. Their role in the immigration could be compared with the previous roles of Germans or Irish in other periods. Since, however, the large western quotas remained unfulfilled and only the eastern European countries reached 100% of the quotas, the total immigration of this refugee group still did not amount to more than 40% of the possible quota. The number of this refugee immigration amounts to 500,000 people in those years, about the same as was the number of aliens already in this country who arrived in previous waves of immigration.

This new group had several differences as compared with the previous immigrant group. Their main reason to immigrate was political and racial persecution. They came with their wives and children and had an exceptionally high percentage of professional people. For instance, there were about 5,000 physicians and dentists among them, mainly from Germany and Austria, amounting to about 3% of all American physicians. The refugee immigrants learned the language more quickly, acquired their citizenship faster than the previous newcomers and gave competition mainly to middle-class and professional people in this country.

The immigration of the third group, that of displaced persons, started in 1945. They showed some similarity to the refugee group in coming over with their wives and children and in the reason for their immigration, which was mainly political persecution. However, they presented many more features reminding one of the pre-refugee immigrant group. Most of them came from the lower class, poorly educated and with a relatively small number of professional people. Their psychological preparation was, however, less than in any of the previous groups. They left their home country or were dragged out of it, were pushed from one place to another and finally landed here. However, many of them never made up their minds to stay definitely in this country. Even more than the pre-war newcomers, they intended to return to their home

From the Chicago State Hospital.

country, and some of them considered the United States for temporary stay only, planning to return to their home country as soon as possible. Most of them came from the eastern European countries, previously being agricultural, non-professional workers or farmers, who never left their country before and never spoke any but their native language.

CASE MATERIAL

This paper is based on observation and psychodynamics of 51 psychotic displaced persons admitted to Chicago State Hospital between the years of 1949 and 1952, somewhat less then three years, amounting to about a half percent of all admissions. The latter number has hardly any statistical significance and cannot be considered as exact. Several of possible D.P.'s may not be included in our material, and several of those who are included may not be D.P.'s in the strict, legal sense of the word. Those who arrived here as regular immigrants are not D.P.'s legally, although psychologically they are not too different from the D.P.'s. Among the 51 cases there are 3 war brides whose special situations are still connected with the general factors of our group.

The distribution of those 51 patients is the following: 22 men and 29 women. One among the men reached the age of 40 years, while 21 are under the age of 35. Among the women 2 are over 60, while 27 are under 50. In most of the cases the diagnosis of schizophrenia was made. Some of them were classified as involutional psychosis, manic-depressive psychosis or psychosis with cerebral arteriosclerosis, but this is of no great significance. Most of them were diagnosed anyway as schizophrenics, and all the other diagnoses meant mainly symptomatic and age differences, while there was a basic similarity among all the patients in the group.

Their two main clinical syndromes were paranoid and depressive reactions. Among the 22 men 15 were paranoid and depressed, while 7 were found to be paranoid only. Among the 29 women 24 were both paranoid and depressive, 2 were paranoid and 3 were depressed only, so basically both men an women show an unusually high combination of paranoid and depressive psychosis. This is somewhat similar to the involutional psychosis, which is so often depressive and paranoid too and which represents to a great part another situational reaction. There is a slightly higher tendency to paranoid reactions in men and to depressive reactions in women; nevertheless, the large number of both reactions in the same patients appears remarkable.

The 51 D.P.'s show the following distribution according to their home countries. 6 are Puerto Ricans and 2 Japanese, and those 8, a minority of the whole group, may present somewhat different features. Among the remaining 43 there are 37 eastern and southern Europeans and only 6 western Europeans. The latter ones are 3 Germans, 1 Belgian, 1 Norwegian, 1 Irish, 2 of the 6 being war brides. The bulk of the group consists of 37 eastern and southern Europeans. Their special distribution is the following: 12 Poles, 5 Lithuanians, 4 Ukranians, 4 Yugoslavians, 3 Latvians, 3 Hungarians, 3 Greeks, 2 Italians and 1 Bulgarian.

Fred K. Hoehler published a booklet in 1946 in the Headline Series of the Foreign Policy Association, entitled Europe's Homeless Millions.[12] As Director of the Division of Displaced Persons in the UNRRA, he compiled statistics about the distribution of displaced persons according to nationality. Of approximately 6,600,000 displaced persons mainly in German and Austrian camps, 5,300,000 were already repatriated at that time, mainly the Russians, furthermore the French and other west Europeans. The remaining 1,300,000 were not yet repatriated and in the opinion of Hoehler[12] probably not repatriable. This non-repatriated group consisted mainly of Poles, Balts (Lithuanians, Latvians, etc.), some Russians (probably mainly from Ukrania), Hungarians, Yugoslavians, Italians and Germans. It is remarkable that our case material about six years later shows nearly the same percentage distribution among the different nationalities. So it looks as if a large number of D.P.'s non-repatriated in 1946 remained displaced, a certain percentage of them immigrated to the U.S.A. and apparently the relative frequency of psychosis among the different nationalities was the same.

Most of the case histories were very similar, although with individual variations. The patients lost in the old country a great part of their family, especially parents, and all their property. They had the terrifying experiences of the war

and German occupation, and some of them later on the Russian occupation. In Germany they were largely in concentration camps and later on in D.P. camps. Upon arrival to this country they were disappointed and not too well accepted by the members of their own nationalities and by some relatives. They all started in low-paid jobs and were all in a financially poor situation. The breakdown did not come immediately but usually in the second or third year after arrival. They became paranoid against their fellow employees, later on against Americans generally, and finally many of them withdrew from life completely and even refused to eat. A large number of those patients was admitted as catatonic and depressed, dehydrated feeding problems to the hydrotherapy wards. Among the married men there were several with the typical paranoia of jealousy. There were three very young men who were looking for their lost father in this country in a delusional manner. Among the women there was a large number of sexual delusions, especially erotomania. Among both men and women the delusion of being poisoned was fairly common.

This very frequent combination of paranoid and depressive reactions does not render our case material a special group of psychosis. Nevertheless, the accumulation of certain symptoms and reactions gives the impression of an accumulation of certain common social and dynamic factors.

The great majority of our cases knew little English, and some of them learned German in the various camps. Very few of them had intellectual professions, most of them being farmers, unskilled workers or housewives. Nearly all of them received intensive treatment, electric or insulin or both. Some psychotherapy was attempted with the Germans and even more with the Hungarians in their native language by the writer.

Social Factors.—The sharp separation of social and psychological factors appears very difficult in our material, as is generally true in psychiatric histories.

There is hardly any doubt about the relatively high frequency of mental illness in the foreign-born population of the United States. Some nationalities have a relatively high frequency of mental breakdown in this country, although the frequency of mental disorders is lower in their own country than here. So we are certainly not dealing here with any differences in the mental health of different races but rather with differences in the exogenous social and environmental factors of some specific situations.

Dayton in his book *New Facts on Mental Disorders*[6], published in 1940, based his material on the observation and evaluation of nearly 90,000 cases of mental illness observed mainly in the New England area. Chapter III deals with nativity and mental disorders. Dayton shows four grades of frequency of mental disorders. They are relatively most frequent in the foreign born, somewhat less frequent in the native born of foreign parentage, somewhat less again in the native born of mixed parentage and relatively the lowest in the category of native-born of native parentage. While the accumulation of factors unfavorable to adjustment is fairly obvious in the foreign born, the role of the foreign or mixed parentage still may need further explanation. Possibly a very important source of mental illness is to be looked for in childhood and in the relation of the child to his parents. So in the case of the native-born child of foreign parents the difference between the two generations may amount to the difference between two civilizations. The child-parental conflicts may be aggravated or at least rationalized by the different social view (especially in sexual matters) of the older generation and may partly account for the higher percentage of breakdown in the better adjusted, native-born child of the less adjusted foreign-born parents. The not-adjusted foreign element should be smaller in the cases of mixed parentage. Here, however, there may be the possibility of greater differences in the marriage of parents.

As for our D.P.'s, a large part of the social factors appears obvious. Their emigration started with loss of members of their families, property and social and financial security. Upon arrival to this country they hardly could reach a situation equivalent to their previous one. Those from agricultural countries had a difficult task to understand the industrial civilization of the U.S.A. One of the main promotors of understanding and adjustment, the knowledge of the English language, was lacking and made them different from the greatest part of the population. Many of them never left their home

countries prior to their displacement and never learned any other but the native language, and they did not prepare to study the new language here. Their social value was hardly appreciated highly here. Many had the typical features of the farmer lost in the large metropolis, somewhat reminding one of a lost child. Their long stay in camps made them more dependent, and their difficulties in making adult decisions and handling responsibilities increased after their arrival in the United States.

The paper of L. Tyhurst[18] in Canada is concerned with a similar number of D.P.'s as in our paper. Her material, however, consists of neurotics rather than psychotics. We agree with her terms of the initial period, followed by the period of psychological arrival. In the first few months of the initial period the newly arrived feel well because of the satisfaction of their basic needs and show a great tendency to ventilate their war experiences. More factors accumulate in the second period, containing already the conflicts which may lead eventually to their breakdown. Their friends here may have less interest in the newly arrived at that time. Their social situation is poor, and having expected all gold lying around in the country of unlimited opportunities they are disappointed in the hard work and low earnings which is their fate for the time being. Many of those middle-aged or early middle-aged people have to start again from the bottom. The language difficulty becomes increasingly significant. In this period many of the new immigrants describe their past as having been unusually happy, with a kind of idealized retrospection.

S. Pedersen[15] in her paper about the refugee neurosis in Sweden finds this condition similar to the war neurosis, with an increasing loss of sense of reality until the breaking point is reached. Her material of mainly middle-class refugees is again not identical with our material of lower-class D.P.'s.

M. Pfister[16] in Switzerland collected questionnaires of 300 refugees from 17 nations. Using mainly the terminology of Kretschmer, he considers as important factors in the breakdown of those uprooted (Entwurzelt) persons the loss of love objects, their loss of ability to life formation (Lebensgestaltung), identification and relation to other people. All those points may result in the loss of ability to love (Liebesfaehigkeit), and then a psychosis may result.

Related to the same problems, J. Tas[17] in Holland wrote about his observations in German concentration camps and S. Davidson[4] about exprisoners of war. Allport and Brunner[1] described 90 life histories of refugees from the Nazis who in the situation of danger were unable to realize it. Margaret Mead[14] in her paper on Cultural Changes Influencing Personality Development considers it as significant that some immigrants came from a homogenous culture, a nearly frozen situation, and some of their problems may be connected with their nostalgia for homogenous views of life.

According to the general terminology our D.P.'s have certainly not only horizontal but also vertical downward displacement in their social situations. The new country brought them usually to a lower economical and social level than they reached before. Not being accepted and recognized by the other people was known long ago as a predisposing factor to paranoid reactions. The old inhabitants and the newcomers may be mutually suspicious of each other. What we don't understand we hardly like; we are afraid and suspicious of it, and finally we may become hostile to it. We know that xenophobia is as old as mankind, and already in old Greece it was considered as the greatest advantage for the traveler to have a friend in a foreign country. The *xeinos,* the friend and host in the strange country or city, was regarded as being very close to one.

The mutual suspicion between the old inhabitant and the new immigrant may have some real basis. The newcomer with his lack of understanding and frustrations criticizes the new country, attempting to judge it in the terms of the old. His relatives or friends here very soon become "fed up" with him, especially if he praises the old country continuously. Sooner or later nearly invariably they give him the sarcastic advice to go back to his ideal old country, forgetting that the immigrant's appraisal of the country could not be entirely objective, since it referred to the image of his country as he established it in his childhood. The competition against the newcomer grows with his success, and the not-understood language may arouse in him the suspicion that he is "sold

out." There is a new type of life here and a new type of food, not easy to adjust to, and this may be a supporting factor for the paranoid delusion of being poisoned. (The real poison, of course, is the mutual suspicion, jealousy, competition and hatred of man toward man.)

Dynamic Factors.—The great emotional significance of the native country or mother country, in some languages called fatherland, was always known and emphasized in literature. Goethe's Iphigenia, a mythical displaced person in a strange country, says: Life does not consist of breathing freely only, apparently expressing the poet's unsatisfied wishes. Lenau, an immigrant in the United States who returned to Germany disappointed, writes about his adventure: The waves of the sea were not blooming and the rough winds were not singing. Apparently the poet expresses here his own frustrations. The Hungarian poet Tompa writes in his letter to an emigrating friend: He who exchanges his country should exchange his heart too, apparently referring to the deep emotional ties connecting one with the native country. Those and many other literary quotations express deep emotions. However, those deep emotional ties may have much more unconscious basis.

In modern psychiatry we consider psychosis as a combination of partial fixation at an earlier stage and regression to this stage of personality and libido development under unfavorable circumstances. At present hereditary factors are not considered as being very important, and there is much more emphasis on early environment. There is a higher integration of endogenous and exogenous factors in the so-called normal personality, and under unfavorable circumstances those will break down who are poorly prepared for adjustment in life. The internal or psychological factors are to a great part products of early environment connected with the personalities and social situation of the parents, so the present separation of internal and external factors may not be too sharp. The psychogenic factors appear sometimes as individual expressions of the social factors.

There is a relatively small number of breakdowns among the displaced persons in this country. Since there is always an accumulation of unfavorable factors before and after arrival here, it appears that those who came here represented already a selected group, the survivors who had a certain ego strength and ability to adjust. In our psychotics the unresolved infantile Oedipal and pre-genital conflicts became revitalized in those situations of stress. The guilt feelings connected with the Oedipal conflict have sometimes some real basis, since after all the immigrants very often let their parents die in order to save their own lives. Now they are reconsidering their own actions, which were directed toward survival, in the light of their frustrations in the new country, so their previous unconscious guilt feelings may be revived.

In our group of psychotics there are combinations of regression to pre-genital levels, both to anal and oral stages. Since Freud the paranoid reactions are considered as expressions mainly of the anal stage, and they are aggravated and promoted by the external circumstances of the D.P.'s. In the psychotic group their marked aggression and projected hostility, on anal-sadistic level, are usually evident, especially in the more aggressive males. The homosexual stage of male libido may be expressed in the delusions of persecution and especially in those of jealousy in the males. Here an additional psycho-social factor may be mentioned, namely that the eastern European men did not become accustomed to the different social situations of the women in the western countries, which, after all, were the pioneers in women's emancipation. The female newcomers have the usual sexual frustrations of the middle-aged or nearly middle-aged women. The fact that they have less chances by being single and especially that they are approaching the involutional age may be a part of it. Another situation is that of the married woman with several children, doing all the housework and even working on the outside, with the resulting emotional disappointment. Those factors may play a role in the erotomanic projections of the women.

Even more evident are the unconscious oral factors. Turning their hostility toward the outside is combined with, preceded by or followed by turning it toward themselves, so there is an unusually large number of combinations of paranoid and depressive reactions, of projection and introjection, spitting out and swallowing their aggressions. Many in our group were admitted

as feeding problems, expressing their childish spitefulness on the oral level, somewhat related to a hunger strike in a jail, revolting against destiny, the merciless jailer.

There is a large number of associations between the mother, the mother's breast, the home country, the home and the native language. The home country was nourishing her children just like the mother did. The names of the countries are of feminine gender in most of the languages, and country and landscape mean usually female and especially mother symbols, as it was pointed out in the writings of S. Freud[9] and other analysts, especially M. Bonaparte[3]. The landscape, with its mountains and valleys, was very often compared with the shape of a woman, both in literature and in jokes. In the English language the home is called sweet. Also in many languages, such as the Hungarian, the native country is called sweet, and so is the mother called, apparently expressing the deep memory of the same early oral pleasure. The Bible refers to the country of promise as flowing with milk and honey, apparently arousing early associations with the nourishing mother, on the oral level.

Those D.P. immigrants were mostly farmers in the home country, having even closer connections with nature, which is called, by the way, mother nature. We may assume that some of those displaced persons never reached complete emotional separation from the mother, identifying her with their home country, and, so their longing meant more than their desire after their lost security only. It was basically identical with the longing after the lost mother. Their idealized retrospection is an allusion to their childhood, the Garden of Eden when they were still without adult guilt feelings. The psychotic D.P. lost both his or her real and symbolical mother, became disappointed in the new country, meaning the stepmother, and now they become feeding problems, which means that they are refusing the stepmother's breast. Their reproach toward the stepmother and adoptive country may not be without some justification. After all, stepmothers rarely love their stepchildren as much as their own children, and the new countries may show some preference, too, for the native-born over those who were not born here and arrived recently. We may mention here that for instance in the Hungarian language sweet children mean one's own children as opposed to stepchildren, so apparently the mutual relationship between stepparents and stepchildren was never too sweet in any country.

Accusations against the mother of giving bad milk to her child are probably unconsciously related to the delusions of being poisoned, which may be supported by the strangeness of foreign food. Bergler[2] and his follower Wormhoudt[19] show close unconscious association between milk and language. In their theory writing and the flow of words are partial compensations and sublimations for the flow of milk.

R. Greeson[10] in an interesting recent article in the Yearbook of Psychoanalysis points out the close associations between the mother tongue and the mother, showing the deeper analytical significance of the native language, which is closer to the unconscious.

The native language is called usually the mother language. The child learned two important oral functions from the mother, to eat and to talk. His baby talk is originally understood by the mother only and is deeply associated with the pleasure and emphasis connected with the early anaklitic oral functions.

S. Ferenczi[8] in his paper about obscene words shows the great emotional significance of those words which are connected with early genital and especially pre-genital functions. They may be connected with the interjectional speech which originally expressed our emotions rather than communicated our thoughts. Logical, reasonable, conceptual speech develops later on and hardly reaches the emotional temperature of the earlier speech. Those early words may appear later on as pornographic words, in excitement and in schizophrenic regressions where the conceptual thinking and speech are partly lost. In some cases of aphasia the logical speech may be lost while the emotional speech, as an earlier phylogenetic and ontogenetic acquisition, may remain or return earlier.

Margaret Mead[14] reports about some tribes were there are two languages, one for the women and one for the men. Originally, however, the women's language is taught by the mother to all the children, while later on the men learn their separate language, so the original language is really a mother language.

As for learning the foreign language, we know that it is largely a realistic and intellectual procedure which may result in possession of the logical contents of the new language. This learning hardly has any more the pleasurable, playful quality of the learning of the mother language, and the original emotional significance may never be reached.

Pronunciation is based on early emotional conditioning, so it is connected with many more difficulties than is the logical expression of the contents. Not so rarely the foreign language of the newcomer remains colorless, partly because of the lack of proper words, partly because of the less intensive emotional connections.

The D.P., just like other refugees, is able to talk in the acquired language as long as he is quiet. However, when he is excited he turns back to the mother language, which is more closely connected with his innermost feelings. The frustrated and excited D.P. returns to his native language in order to curse, to find emotional outlets not open for him in the new language, and there he may use the forbidden genital and pre-genital, non-dictionary words pertaining to infantile sexuality. While the newly acquired language is highly cultivated, is full of inhibitions and, as Greenson[10] believes, is in closer relation to the superego, the native language has more to do with the Id. There seems to be some analytic proof for the assumption that the original visual images are more associated with the mother language than with the new language and again more with the emotional than with the intellectual speech. In his regressive breakdown the D.P. may make use of all the forbidden expressions in his own language, (for which nobody but the mother could forgive him). The newcomer is usually resented by the people of the new country for talking in his native language. In this country most of the people do not understand it, and sometimes they may not be entirely unjustified in considering talking in a foreign language as an expression of hostility and secrecy.

A few remarks about the 3 war brides (1 German, 1 Italian, 1 Belgian) who were included in our group. They may have had originally intensified superego conflicts. The German war bride, for instance, who was taught to hate the enemies of her country, married later to one of the representatives of the conquerors, so besides practical reasons her marriage appears as an unfaithfulness to the father somewhat more than the average marriage. We could compare the situation until a certain degree with Freud's[9] description of the war neurosis as an expression of the conflict between the original peace superego and the parasitic war superego. On the other hand, marrying a member of the hostile group, nation or family (such as in Romeo and Juliet), was always considered as building a bridge between artificially separated parts of mankind, and this expression of humanistic approach appeared especially feminine. As Antigone of Sophocles says: I was not born to hate but to love.

After her arrival the war bride may have had increased difficulties in adjusting to her new family with their different backgrounds and jealousy of her. One of the most common conflicts is the struggle between mother and wife for the emotional possession of the man. As the warbrides reported, they were never able to call their mother-in-laws mother. Those and other factors may play a role in their eventual breakdown.

Most of the cases of the displaced persons in our group had a large number of exogenous factors in their breakdown. Tough reality precipitated and revived infantile conflicts, and many of our patients may not have broken down without those serious external reasons. Based on our description, we are dealing mostly with schizophrenic reactions rather than true schizophrenias. These cases are accessible to treatment, and their prognosis in the average is relatively favorable.

SUMMARY AND CONCLUSIONS

1. 51 cases of psychosis in displaced persons admitted to a state hospital during the last three years were observed and evaluated. They came largely from east European countries. 2. Those displaced persons showed some similarities to the previous immigrant group of refugees. In contradiction to them, however, they were rather pushed by the circumstances to come here than decided by themselves for immigration and considered their immigration more as temporary only. 3. Some special factors in this group of psychotic D.P.'s were pointed out, especially their origin from agricultural countries, which

made them more similar to the pre-war immigrants. 4. Their previous traumatic experiences, poor social situation and lack of knowledge of the language contributed to the paranoid psychosis which they developed. 5. The large number of depressive psychoses, especially refusal of food, points to the significance of oral factors and unresolved relations to the mother. 6. The unconscious connections between mother, mother country and mother language were pointed out, showing again the great significance of oral factors in their regressive psychosis. 7. There is a close correlation between the psychological and social factors, which sometimes appear as two sides of the same phenomenon. 8. Social, psychological and biological elements are highly integrated in the normal personality, mental illness meaning mainly the disintegration of those component groups.

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PLAN DURING BREATHING SPELL

It is my feeling that a plan must be devised in medicine to preclude any possible necessity for its becoming political. I believe that a volunteer plan of the Blue Cross type is best but that perhaps some local subsidization may prove necessary, as has been the case in general hospitals. Other reasons for this include the physician's too frequent misuse of the Blue Cross, the lack of an informed populace, and the to date poor public relations job done by medicine. Fortunately, there is evidence of moderate but definite progress in the last two. Obviously, there will be less stumping for a nationalized plan here for the next two to four years, which fact presents the ideal breathing space for positive action and the formation of a plan to bring to the public before politicians back us to our "no" wall again. The difficulty lies in the physicians' easy course of criticism with few doctors seeing beyond their own practice in the effort of establishing a necessary policy. This can be rectified by co-operation, not the type demonstrated in the British Medical Association. *James Rogers Fox, M.D., Inside The British Health Plan. Minnesota Med., Feb. 1953.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Paraphysial Cyst of the Third Ventricle of the Brain

Ruth E. Burrows, M.D.
Chicago

Since the first description of a colloid cyst of the third ventricle of the brain by Wallmann[1] in 1858, approximately forty-five of these cysts have been reported. Apparently rare, they cause symptoms which, if recognized, could lead to diagnosis and removal. Frequently the antemortem diagnosis is impossible and death occurs suddenly in one of the bouts of headache.

A white woman, aged 48 years, employed as secretary by a physician, was admitted to St. Luke's Hospital on February 19, 1953, in a stupor. On February 17, 1953, she had complained of a moderately severe frontal headache which subsided in the evening. She had no headache the following morning and went to work as usual. About 3 P. M. she again suddenly had severe frontal headache, but continued her work for an hour or two, and arrived home about 6 P. M. The pain was so severe that she did not eat supper, and she went to bed without disrobing. There were no other symptoms. About 10 P. M. the pain localized in the right temporal region, and at midnight she vomited. She was restless during the night and at 4 A. M., February 19th, she was incoherent and did not respond to questions. At 6 A. M. vomiting recurred, the patient was incontinent, and she was brought to the hospital.

She had been in good health, but had remarked that she was unusually sleepy in the afternoon for a week preceding the attack. The past history otherwise was non-contributory. She had had a bilateral saphenous vein ligation in 1946 and a cholecystectomy in 1947.

Her temperature was 96.4 F. rectally, the pulse was 68 and the respirations were 18 per minute, and the blood pressure was 160/90 mms. of mercury. A neurological examination revealed fixed pupils, the left slightly larger than the right, and the eyes conjugately deviated to the right. Respirations were stertorous and the patient was restless, moving the left arm more than the right. Tendon reflexes were brisk bi-

From the Henry Baird Favill Laboratory of St. Luke's Hospital.

laterally and plantar stimulation yielded dorsiflexion of the great toes.

The spinal fluid in the third tube was clear. The initial pressure was 300 mms. of spinal fluid. The patient's respirations became heavily stertorous, the spinal puncture needle was withdrawn, and 30 minutes later the patient expired, two hours after admission. Examination of the spinal fluid revealed 307 red blood cells, 19 polynuclear leukocytes and 7 lymphocytes per c. mm. The amount of fluid was insufficient for a total protein determination.

Necropsy: Necropsy was performed three hours after death (Edwin F. Hirsch). The leptomeninges were thin and translucent. The cerebral hemispheres were symmetrical but the convolutions were flattened and the sulci correspondingly narrow. When the lateral ventricles were exposed through medial incisions the lumen of each was dilated to 10 by 5 by 4 cms. and filled with a large amount of clear fluid. On lifting the septum pellucidum and exposing the interventricular foramina, a globule of tan-brown, thick mucinous material 1.5 cms, in diameter floated in the third ventricle opposite the infundibulum and obstructed the interventricular foramina. The origin of the mucinous material was seemingly from a ruptured cystic structure of the infundibulum. The aqueduct of Sylvius was not obstructed or dilated. The fourth ventricle had no unusual changes. A probe passed into the stalk of the infundibulum from the floor of the third ventricle revealed a widely patent passage which extended through to the hypothalamus. This channel could be further distended with a little pressure. The choroid plexuses of the lateral and fourth ventricles were not unusual. No other significant changes were demonstrated elsewhere in the body by necropsy examination. The brain weighed 1340 grams before the distended ventricles were opened.

Microscopically the wall of the cyst was a thin layer of fibrous stroma and the simple lining cells varied in size, some being moderately tall, others low and cuboidal (Figure 1). Among the tall variety many had pale vesicular basal nuclei with a large amount of brown granular cytoplasm, and were ciliated. The cytoplasm of some had large pale vacuoles as though secreting mucin. In the fibrous stroma were a few polymorphonuclear leukocytes and small dilated blood vessels. A few choroid plexus villi with the usual structure were along the outside of the cyst wall. The homogeneous eosinophilic material within the lumen of the cyst contained a few scattered polymorphonuclear leukocytes. Serial sections through the stalk of the hypophysis disclosed no abnormal structures.

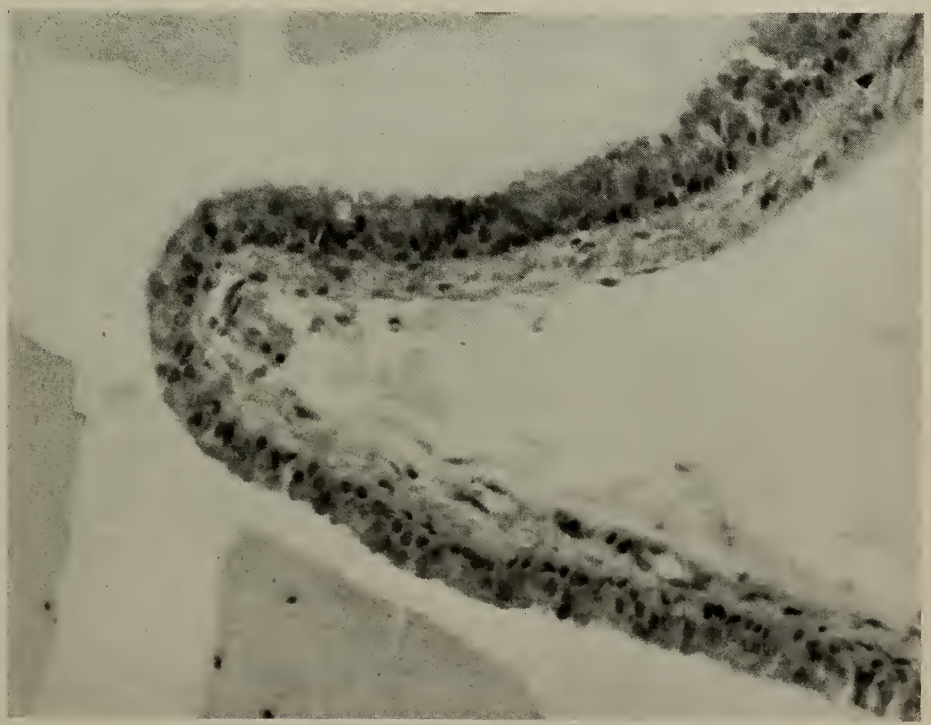


Figure 1: Photomicrograph illustrating the columnar cell lining and the thin fibrous wall of the paraphysial cyst. Note the vacuolated cytoplasm and brush border of some of the lining cells and the mucinous material in the lumen.

DISCUSSION

Colloid cysts of the third ventricle are reported to arise from the fetal ependyma, from the choroid plexus and from the paraphysis. Their position at the rostral end of the third ventricle supports the view that they develop from the paraphysis. Zeitlin and Lichtenstein[2], in their excellent review of the pathogenesis of these cysts, stated that the choroid plexus of the lateral ventricles develops from the paraphysial arch, and the plexus accordingly derives from the anterior and posterior end of the septum transversum. The paraphysis takes origin immediately in front of the velum transversum so that the rudimentary paraphysis is surrounded by the choroid plexus. Cysts of the choroid plexus differ from the "colloid" cysts in that they have a transparent wall and are filled with a clear, watery fluid. Paraphysial cysts are characterized by a thicker fibrous outer coat, lined by an inner layer of ciliated cuboidal epithelial cells and containing mucinous material. Zeitlin and Lichtenstein[2], Rinder and Cannon[3], and Zimmerman and German[4] have described such cysts. Characteristic of all are the tubular formations and the secretory nature of the epithelial cells. Sjovall[5] demonstrated the presence of lipochrome granules in the cytoplasm of these cells with scarlet red stains. Others have demonstrated secretory activity with concentrated sulfuric acid, the lipochrome substance being indicated by blue discoloration. In my case, special stains failed to reveal lipochrome granules. However, secretory activity is indicated by the tall epithelial cells with pale vesicular basal nuclei, a large amount of brown granules and pale vacuoles in the cytoplasm.

The published accounts of these cases mention symptoms as varied as the histories are incomplete. Zimmerman and German[4] and Stookey[6] have collected the cases reported. Increased intracranial pressure, causing headache, vomiting, vertigo, loss of consciousness, mental dullness, loss of memory or confusion, are the commonest. These symptoms may occur with neoplasms of the lateral and fourth ventricles and with tumors of the posterior fossa. Accordingly they do not characterize a third ventricle tumor. However, the symptoms with colloid cysts do have some specific characteristics. Most of them cause severe frontal headaches, usually over one or both supraorbital regions; then almost regularly there is a sudden and dramatic onset of symptoms, probably related to the sudden obstruction of either the foramina of Monro or the aqueduct of Sylvius by the movable cyst; and finally there is a remission of the symptoms which also is attributable to the movability of the cyst and is related to an unblocking of the passageway of the cerebrospinal fluid in the ventricle system.

These severe paroxysmal headaches may be due to sudden obstruction of the lateral ventricles at the foramina of Monro. At the same time the compression also interferes with the venous outflow of the choroid plexus of both lateral ventricles and the third ventricle. The choroid vein from the choroid plexus of the lateral ventricles and the terminal vein unite at the foramen of Monro to form the internal cerebral vein. The terminal vein receives tributaries from the corpus striatum, optic thalamus, frontal horn and septum pellucidum, while the choroid vein, besides draining the choroid of the lateral ventricle, receives the vein from the choroid plexus of the third ventricle. Accordingly, the only venous drainage for all the choroid plexuses is through the internal cerebral vein at its origin, and compression at this level permits no collateral circulation. Blockage by impaction or sudden swelling prevents the venous drainage and hence a rise in capillary pressure in the choroid plexus in the lateral ventricles and the third ventricle. This leads to an excessive production of cerebrospinal fluid in an already obstructed ventricular system[6].

Surgical intervention when the condition is recognized can relieve the symptoms of these tumors and save the life of the patient. Dandy[7] turned down a bone flap as in a pineal approach, and split the corpus callosum posteriorly for about 5-6 cms. Cushing[8] proposed a two stage operation when the ventricles are not dilated. Stookey[6] approached the third ventricle through a transverse incision of the cortex into the lateral ventricle in the region of the right middle frontal gyrus, well anterior to the precentral convolution, in a single stage.

As such operative measures entail danger, careful diagnostic procedures must supplement the history, symptoms and neurological find-

ings. Such measures have been offered by improved roentgenological methods, encephalography and ventriculography, or combinations of both. Davidoff and Dyke[9] in 1936 reported on nine patients with congenital tumors of the third ventricle treated surgically. Six of these lived, and three died shortly after their operation. Davidoff and Dyke summarized the important elements in diagnosis.

In an encephalogram a tumor of the anterior portion of the third ventricle is indicated by a) symmetrically dilated lateral ventricles without displacement; b) a filling defect in the anterior portion of the third ventricle with a convex or straight posterior edge; c) a normal or slightly dilated Sylvian aqueduct and IV ventricle; d) an incompletely filled or deformed cisternae interpeduncularis and pontis; and e) dorsally displaced medial cerebral sulci.

With a single puncture ventriculogram, the positive findings are a) failure or difficult passage of air into the opposite or third ventricle; b) deviation of the septum pellucidum to the right or left side of the midline; and c) a filling defect in the anterior portion of the third ventricle with a convex or straight posterior edge.

With a bilateral puncture ventriculogram there are a) symmetrically dilated lateral ventrices; b) obstruction of the air shadow at the foramen of Monro; and c) the filling defect mentioned in the preceding paragraphs.

A defect in the septum pellucidum can be diagnosed by the shadow of the septum in the antero-posterior view and a fusion of the lateral ventricles across the midline.

With effective methods of diagnosis and treatment, the responsibility of diagnosis rests with the examining physician.

SUMMARY

Colloid cysts of the rostral end of the third ventricle probably are embryological derivatives of the paraphysis. They have a fibrous wall, are lined by ciliated cuboidal epithelium, and contain mucinous secretion.

By obstruction of the circulation of the spinal fluid at the foramen of Monro they cause acute intraventricular pressure with headache, vomiting, vertigo, loss of consciousness, mental dullness and loss of memory or confusion. Death may occur in such a syndrome. The onset of symptoms is sudden and relief is related to unblocking of the obstruction.

Surgery is the only hope for relief and frequently death occurs without a correct clinical diagnosis.

Characteristic symptoms of the disorder and procedures for diagnosis are discussed.

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EDITORIALS

KEEPING ABREAST OF THE PATIENT

The laity today is being educated in medicine so rapidly the physician often finds it difficult to keep posted on new concepts and therapies. Many embarrassing situations have resulted and occasionally the physician, against his better judgment, is forced to prescribe a remedy that has been ballyhooed to the skies. Scientific news has public appeal and so long as reader interest continues at a high level, publishers will accept material of this nature. It has proved a boon to science writers and to the public relations department of medical schools and societies, hospitals, fund raising organizations, and last but not least, pharmaceutical houses, large and small, ethical and otherwise.

The profession has always regarded a little knowledge as a dangerous thing but times and ideas are changing. On many occasions, a better understanding of disease has helped the doctor-patient relationship but public educational programs also have created problems. Widespread publicity on cancer, for example, has made more and more patients seek earlier medical consultation. This is what physicians have been preaching for years but what has happened? In some instances the practitioner has failed to equip himself so that he can follow through on the investigation. In others, early symptoms and findings are not given proper recognition because they do not conform to the classical manifestations that years ago he learned to associate with malignancies. As a result, minor complaints are pooh-poohed so that the patient will not worry; or distress is considered too insignificant to warrant the laboratory studies necessary to rule out tumors. Should cancer actually be present, diagnosis is thus delayed, which brings us back to where we were 20 years ago.

The problem can be overcome by familiarizing ourselves with the earliest manifestations of the disease and by paying more attention to mild symptoms. But human nature also enters the picture. How often does the average physician miss a gastrointestinal cancer by not thinking of malignancy when abdominal symptoms develop? Paine[1] has estimated that each of the 100,000 general practitioners in America will see less than one gastrointestinal cancer every 18 months. During the same period, each is consulted by hundreds of patients with vague and indefinite abdominal complaints due to a variety of functional or benign lesions. It is here that judgment enters the picture, a diagnostic procedure that science writers and armchair strategists seldom take into consideration.

1. John R. Paine, M.D., Early Diagnosis of Carcinoma of the Gastrointestinal Track. J. Indiana M.A., Aug. 1953.

DOCTOR-DRAFT LAW OPERATION TEMPORARILY HALTED

Since the printing of the article "What The New Doctors' Draft Law Means To You", in the September issue of the Illinois Medical Journal, the National Advisory Committee has informed all of the State Advisory Committees that there will be a cut in the calling of Special Registrants by Selective Service in the future.

The National Committee states it is not expected there will be additional calls for physicians placed against the Selective Service System by the President for the next twelve months. The reason for this is because of the tremendous number of volunteers and the cut in the number of physicians allowed the Armed Forces by Congress. Those now having commissions, due to volunteering, or those who were on the last Special Call of Selective Service, will form a pool and those individuals will be brought to active duty from time to time until the reservoir is exhausted.

Fifth Army Headquarters has informed us that they will no longer commission men in the medical corps, nor will they tender commissions to any physicians who are Special Registrants until such time as all of those previously commissioned have been ordered to active duty. When a physician is ordered for induction as a regular registrant, the Army *will try* to commission him and get him on to active duty prior to the date of induction. Any physician ordered for induction as a regular registrant should immediately contact Fifth Army Headquarters to get information relative to obtaining a commission and entering upon immediate active duty.

In spite of the cutback in the call of Special Registrants, the National Advisory Committee has informed us that we should watch the situations in communities, medical schools, hospitals, etc., so when calls are reestablished we will find only, as an unusual exception, any of those who are liable, in essential positions. This Committee will, therefore, continue to review the cases of individuals whose essentiality expires to determine whether they may be considered available or whether further essentiality should be recommended so that at such time Selective Service or the Department of Defense start to call individuals to active duty, the Advisory Committee will not find itself with a backlog of work.

AMERICAN ACHIEVEMENTS IN SCIENCE AND INDUSTRY

The Museum of Science and Industry, located at 57th Street and South Lake Shore Drive, Chicago, has accumulated an enormous amount of exhibit material to show American achievements in science and industry. Under the supervision of Lenox R. Lohr, these many interesting exhibits have been well arranged and should be of interest to both adults and children.

Eight acres of dynamic visitor-operated exhibits disclose "how science discerns the laws of nature and how industry applies them to the needs of men". You can see yourself on television, listen to your own telephone voice, walk down yesterday's main street with its old fashioned nickelodeon, visit the modern farm and take a trip through a coal mine. Then the antique car exhibit will be of interest to everyone; all of these cars in running condition.

It is interesting to note in this fine exhibit, the many obstacles the pioneer automobile manufacturers had to overcome to gradually improve this important mode of transportation from cars whose operations were unpredictable, to the modern automobiles with many thousands of miles of service assured. Then, the old auto tires with a maximum guarantee of perhaps 3,000 miles of service, to those of today which give many thousands of miles before they need to be traded in for a new set.

An interesting and new addition to the exhibit, is the "story of rubber", in which the story of rubber in our present day economy has been well presented. The modern tubeless tire is shown, one of which has been punctured many hundreds of times and still retains its air pressure.

This interesting Museum, located in Jackson Park has many exhibits of general interest to grownups and children alike, and it is well worth a trip to Chicago for those living in Illinois or adjoining states, to spend at least a day seeing the many things developed by science. Admission to the museum is always free, there is plenty of good parking space, and a cafeteria, luncheonette and picnic room open daily.

Major Lenox R. Lohr, President of the Museum of Science and Industry extends a cordial invitation to all physicians to come to Chicago and visit the Museum.

NEW PAVILION FOR PASSAVANT HOSPITAL

Former members of Passavant Memorial Hospital's medical staff, who had prominent roles in the development of the Hospital, and who were all members of our Society will be honored by commemorative units in the new South Pavilion.

The Commemorative Committee, which will undertake to finance these memorial units to Passavant doctors—deceased or emeritus—is one of the coordinated efforts of the building fund campaign which will be under the direction of Gilbert H. Scribner, Jr. Solicitation for the Commemorative Units will be only among friends and colleagues of the doctors being honored.

Commemorative Units so far organized for action are the following:

Dr. Marion H. Barker, who was Associate Professor of Medicine at Northwestern and one of the founding members of the American Society for the Study of Arteriosclerosis. Dr. Barker was awarded the Legion of Merit in 1945 for his outstanding service in World War II. He died in 1947.

Dr. Arthur Byfield, Associate Professor Emeritus of Medicine, who has made extensive contributions to the literature of medicine on all phases of internal medicine.

Dr. Arthur H. Curtis, Professor Emeritus of Obstetrics and Gynecology and former Chairman of the Department at Northwestern University Medical School and Passavant Hospital. Dr. Curtis' *Textbook on Gynecology* continues to be one of the authoritative works in the field.

Dr. Sanford R. Gifford, who was Professor of Ophthalmology and Chairman of the Department at Northwestern and Passavant. Dr. Gifford's two textbooks are still widely used. He died in 1944.

Dr. David S. Hillis, who was Head of the Obstetrical Department at Passavant and Professor of Obstetrics and Gynecology at Northwestern University Medical School. Dr. Hillis is credited with numerous advancements in obstetrical practice which are used throughout the world. He died in 1942.

Dr. Walter H. Nadler, who was Associate Professor of Medicine at Northwestern, was President of the Staff at Passavant and Chief of its medical service from 1943 to 1950. He was also president of the Central Society for Clinical Research. Dr. Nadler died in 1952.

Passavant Memorial Hospital was founded in 1865. Through its affiliation with the medical school at Northwestern, it conducts a continuous program of teaching and research. Every member of its staff is also a member of the Medical School faculty.

The new building will provide the Hospital with 100 more beds, and additional teaching beds. It will also provide expansion and improvement of present facilities, teaching and laboratory space with specialized areas for various departments.

The cost of the new South Pavilion, including extensive remodelling within the Hospital, will be $3,000,000. More than half of the amount needed has already been subscribed by individuals, firms, and foundations.

SOCIAL SECURITY BENEFITS FOR THE DENTIST-VETERAN

John L. Krause, D.D.S.*

If you were in the military service for a period of at least eighteen months between September 16, 1940 and December 31, 1953 you are now eligible for Social Security credits. This might mean as much as $10,000 in benefits to you or to your family; yet many dentists who are veterans, and their families, will lose substantial amounts by not being fully aware of and taking advantage of their rights under Social Security laws. To inform them is the purpose of this article.

Any veteran who was on active duty in any branch of our armed services between September 16, 1940, and December 31, 1953 has been credited for each month of service with $160.00 per month toward Social Security benefits, *if he has served at least* 90 *days and was not dishonorably discharged. However, military service credits may not be counted toward benefits if a monthly benefit based on the same period of service is payable by some government agency*

Dr. Krause is Professional Service Representative in Chicago for the Equitable Life Assurance Society. **This entire article was checked by the Social Security Administration Field Office in Chicago, and is reproduced because it also applies to the physician-veteran.**

From *The Fortnightly Review*, Chicago Dental Society, Aug. 1, 1953.

other than Veterans Administration. Some dentists who have seen military service may have accumulated Social Security benefits before and since their period of military service. In such cases the credits earned will be added to those accumulated while in service and resulting benefits will be increased accordingly.

Since Social Security coverage was extended on January 1, 1951, all former credits including those earned while in military service may be effective from that date. Thus, dentists who have had active military service since September 16, 1940 may be now eligible for Social Security benefits.

Survivors' Benefits.—To be eligible for survivorship benefits, the veteran must have served at least eighteen months on active duty. For each quarter-year of active military service, the veteran will be insured for another quarter-year subsequent to 1950. For example, a dentist who put in five years of active duty (sixty months) has earned ten years' coverage. This would run from January 1, 1951 so that he could be "insured" through 1960—a period of ten years. If he died within that ten-year period, a widow with two or more minor children would be entitled to no less than $40 monthly until the children reach eighteen. If death occurs after this period, no benefits are payable unless you are covered by Social Security by being in what is known as "covered employment." The normal dental practice is not "covered employment."

Retirement Benefits.—To be eligible for retirement benefits—that is benefits that will come to you at the time you retire—you must have accomplished a "Fully Insured" status before you reach age sixty-five. To do this may require as many as forty calendar quarters—a total of ten years of coverage between January 1, 1937 and the date of your retirement at sixty-five. For example, if the dentist mentioned above who had five years' active duty and thus had five years of Social Security coverage could acquire another five years in "covered employment" before age 65, he would then have his forty quarters of coverage and be fully insured upon retirement. This would provide income to the man and his wife for life.

Exceptions to the effective starting date of January 1, 1951 for World War II veterans are those who served on active military duty after World War II and before December 31, 1953. In this category, wage credits of $160.00 per month may be counted toward Social Security benefits as of September 1, 1952. For example, a veteran who was called to active duty on the first of January, 1951 and was separated on December 31, 1952, two years, or twenty-four months later, will have an insured status for forty-eight months or until September 1, 1955.

Social Security benefits are of immediate value to many survivors of men who died in military service as well as to survivors of dental veterans who died after discharge. For example, a dentist may have died who served in World War II for a period of eighteen months, having no previous Social Security coverage. His widow and dependent minor children may now be eligible for monthly Social Security payments on the basis of his military service credits alone. In addition, a lump-sum payment would be made if he died after August, 1952. This lump-sum payment would amount to not less than $75. The person entitled to this payment has two years from date of death in which to claim it.

It is not necessary to have a Social Security card in order to receive military wage credits. The wage credits of $160.00 a month are not added to Social Security records year after year like other earnings but are put into the record at the time a claim is made for retirement or survivors insurance payments.

Social Security payments are not made automatically. Before payments can begin an application must be made by the veteran or his survivor. Applications can be obtained from the Social Security Administration field office in your vicinity. When an application for benefits is filed late, back payments may be made for no more than six months.

For those who have had employment under Social Security, your records may be checked by requesting a postcard Form OAR-7004 from your Social Security Administration field office. Offices are listed in the telephone directory. You should be fully aware of your status at all times.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Wake Up!

Let's admit it! As a group, the doctor is in the public's dog house. And the darkest corner of all is inhabited by our own A.M.A. If you have some doubts about this just read any daily paper or nationally circulated magazine.

Yet as an individual, the doctor is still a venerated soul. Great numbers continue to have faith in him and seek his advice, his skill and his art. Surveys such as that conducted in Decatur (Macon County) emphasize this fact. Nearly everyone loves his own doctor. At least he respects him.

But as a group—what is wrong with us? Our accusers feel that we are too concerned with our own selfish interests. Money, especially large fees; no night calls; no house calls; long vacations; days off for golfing; and expensive automobiles are said to be our main pre-occupations. We stand accused of being conservative fuddy duddies, still living in the gay nineties, and unaware of social progress. Some even add to all this the sentiment that we are not interested in preventing illness nor in getting patients well quickly.

And all this in the face of our reaching the golden era of medicine. As of 1953 we have helped or been the major factor in adding years to life's expectancy, have brought many infectious diseases under complete control, have made childbirth safe, have greatly reduced infant deaths, have enlarged the surgeon's realm toward unhoped for successes, and have even lessened the tragedies of war.

With all this tremendous increase in the health of our community, why should we physicians stand accused? Perhaps the motivating factors are deep subconscious ones? More likely it is truly our fault. Even the greatest of prophets was completely misunderstood.

Let's admit it! We are not experts in public relations. Let us accept the truth, but above all, wake up, and do something to change this deplorable state.

Where do we start? Right in your office and my office. Right in your hospital and my hospital. Right in your town and my town. When do we start? Now!

The essence of good medical public relations is to see a sick person promptly when called, to relieve pain as quickly as possible, to leave no stone unturned to make an accurate diagnosis,

and to get him well as fast as God's will will permit. During this time it is our obligation to remain humble, sympathetic, understanding, and steadfast in one's duty, and charge a reasonable fee. The actual performance of such Hippocratean acts by almost 100% of our profession is the reason why the individual doctor is held in such high esteem. Loud talking and bellicose shouting about the less than one per cent who fail place the group in jeopardy.

Let's clean house! We have grievance committees in each county. See that they are active. See that they give both patient and doctor a square deal. Don't sit back when a colleague is in error. Talk to him, straighten him out. Stick up for what's right. There can be only one set of ethics. Help uphold our principles. Bring the detractors to justice. To do this we don't need the help of the newspapers, radio, or allied medical organizations. Let's rehabilitate our family delinquents ourselves. It's when we fail to do this that someone runs to the public courts. Let's not waste our energy fighting individuals and groups who shout at us. Let's use this energy in correct curative action.

Let's work together. Our Illinois State Medical Society has an excellent public relations committee headed by a vigorous fighting chairman who knows and understands the problem. But he can't do it alone. At our last annual state meeting he arranged two excellent symposiums on public relations. One even included a free dinner. And yet only a handful of doctors attended the conferences. How can our big brass function if we sit around and fail even to cooperate? If you have read this far, there is hope. Get busy, go to your county society meetings. If you can't do anything else to help, gripe and complain. At least show your interest. Better yet, in a purely scientific manner reason our excuse for a "poor press" and work on constructive helpful ideas.

Let's tell the story—Why wait for our public relations committees to do all the job? Speak up whenever you can about our successes. Tell about our A.M.A. and our Illinois State Medical Society. Describe our annual conventions. Talk about our TV and radio programs. Recognize our faults and tell what we are doing to eliminate them.

And above all let each of us continue to keep his ideals high, his ethics pure, and his patients' welfare paramount.

FORTY YEARS OF STUDY

One common objection is that fluoridation still is in the experimental stage. Surely over 40 years of study and experimentation and observation on several million human subjects belies that charge. No other health procedure has been based on such a wealth of experience before being offered to the people of this country. A charge often heard is that fluoridation is mass medication. As health officials I am sure you are aware of the similarity between fluoridation and chlorination. Neither treats or cures a disease but each prevents disease. Both are wholly preventive measures. As mentioned earlier, fluorine is a normal constituent of many public drinking waters ranging from a trace — 0.1 ppm or less — through the ideal range of 1.0 to 1.5 ppm and up to definitely excessive amounts. Thus, controlled fluoridation is just that — control of an element usually present in water supplies so that communities can produce the optimum range of concentration. *Frank E. Law. D.D.S., M.P.H., Fluoridation — A Positive Protection. Pub. Health News (New Jersey) Aug. 1953.*

THE P.R. PAGE



Editor's Note: With this issue, the Journal begins a new and important activity — a monthly page devoted to the subject of medical public relations in Illinois. It will be prepared by the Committee on Medical Service and Public Relations and is generally intended to serve for the exchange of ideas, reports of praiseworthy public relations work by individuals and county societies, and as a bulletin board for The Committee.

The Committee solicits, first, your earnest attention, and second, your support. Send in news of what you are doing, and ask questions if you like. The Committee's address is: Room 902, 185 North Wabash Avenue, Chicago 1, Illinois.

New P.R. Pamphlet Due Soon:

The most important public relations news of the month is the preparation of a new pamphlet, "The Public Relations of County Medical Societies: Outline of a Program." Short title. "P.R. Outline." The pamphlet, prepared by the Committee on Medical Service and Public Relations, is intended to serve as the fundamental document for county public relations programs. It numbers thirty-eight points of importance to good medical public relations, from good society and committee organization to press relations, summarizing in brief form the countless directions, suggestions and examples which have flooded the mails over the last few years.

The Committee hopes that each secretary and P.R. chairman will study it carefully and check his own society organization and program against its recommendations. Questions and comments are invited. The pamphlet is now ready for the printer and all should receive copies within a few weeks.

Other Pamphlets in Prospect:

Two other pamphlets are being prepared by the Committee — one on voluntary insurance, the other on rural health. Material and ideas are being collected as this is written. Suggestions will be welcomed.

P.R. Maxim:

The prophet who is not without honor but in his own country, "suffered unpopularity because he failed or for some reason found it impossible to identify himself in his neighbor's minds with the community interest." —James W. Irwin in "Your Public Relations."

The Summer:

Two council meetings, a committee meeting, two big fairs and new pamphlet plans kept the summer a busy one.

The Sangamon County Medical Society, under the guidance of Dr. Jacob E. Reisch,

Councilor for the Fifth District, and the Woman's Auxiliary, did their usual fine job in establishing and staffing a booth at the Illinois State Fair. An animated cartoon motion picture on "How to Catch a Cold," along with three other films, stopped thousands of people to look at three fine A.M.A. supplied exhibits and to accept — and carry away — more than 80,000 pamphlets. Attendance at the fair was over a million.

Two weeks later the Du Quoin State Fair saw its first society-sponsored exhibit. The same four movies and two exhibits again stopped thousands of the 350,000 people who attended. They carried away more than 20,000 pamphlets.

The Perry County Society, with the help of Dr. W. W. Fullerton, 10th District Councilor, made the arrangements. An unusual angle was that the doctors' wives, who never had had an auxiliary, formed one in order to staff the show — which made auxiliary leaders happy.

A third event which also illustrates the supreme importance of the Auxiliary in medical public relations, was the Kankakee County Fair. The State Society does not sponsor county fair exhibits, but the members of the county's Woman's Auxiliary, with Mrs. H. P. Swartz, as nurse recruitment chairman, in charge, decided to have a nurse recruitment booth. It was a complete success. They set up a tent equipped as a hospital room, gave away a huge doll dressed as a nurse, and altogether succeeded so well as to register seventy-six high school girls as interested in a nursing career. Auxiliary members and student nurses staffed the booth. They had good publicity in press and radio.

Space is Running Out:

The A.M.A. P.R. Institute September 2 and 3 was a great success. Mrs. Henry Christiansen of Chicago, State Auxiliary president; Mrs. A. T. Kwedar of Springfield, president-elect; Mrs. R. E. Davies of Spring Valley, P.R. Chairman; Dr. C. Elliott Bell of Decatur, Macon County president and P.R. chairman; and Dr. Robert E. Heerens of Rockford, Winnebago P.R. chairman, with Douglas A. Thorsen, Winnebago executive secretary, were in attendance, along with Dr. Walter C. Bornemeier, Dr. Frank H. Fowler, and Dr. Eugene T. McEnery, president, president-elect, and past president, who represented the Chicago Medical Society.

Future pages, according to plan, will go into some detail about the fine P.R. programs being carried on throughout the state — in Chicago and Winnebago, Adams, Macon and other counties. It is expected that some interesting material on Macon's insurance program will be made available on slides and transcriptions by the State Society for any county society desiring to present it. More on that later.

In the next few months, between 150 and 200 top Chicago men will take one or two days out of their busy weeks to participate in 20 or more downstate postgraduate education conferences now being set up.

One more note:

Don't forget to select an outstanding general practitioner for your county, publicize his achievements locally, and submit his name as a candidate for state and national outstanding general practitioner. A really valuable P.R. technique!

KNOW YOUR SOCIETY

COUNCIL COMMITTEES (Continued)

In the last issue of the Illinois Medical Journal, the section on "Know Your Society" carried a general summary of the various advisory committees working under the direction of the Council and appointed by its chairman. Since some 35 committees are appointed each year to function from May 1st through the next April 30 as the fiscal year of the Society, this general summary of the committees and their activities will constitute the material presented in this section of the Journal for several months. The committees are listed in the secretary's office files in alphabetical order and will be outlined in that manner in these articles.

(1) Committee on Blood Banks. The last detailed report of this committee's activities was given by its chairman, Dr. Coye C. Mason, to the Council in March of 1953. The committee discussed a plan to cooperate with Civil Defense, where a real need exists. The Council was requested to ask the Illinois Society of Blood Banks (through its Blood Bank Committee) to develop and furnish the committee with a list of the names of people concerned with the blood bank programs in each area. Also a setup of regional centers was considered (eight or eleven in Illinois). These centers would be the central foci for blood bank problems.

Also the committee considered the value of a series of talks on stored blood and the indications of danger in blood transfusions when blood is used too much. The county medical societies were considered as a good outlet for these talks throughout the state, and members of the committee are willing and anxious to appear as speakers.

The committee works with the Department of Public Health laboratories in its program of cross matching, etc., so that the laboratories will conform to the main standards. If Illinois has blood banks which are using the same technique, then the goal (a state wide program) could be realized. At the present time, for instance, in the State of California, you can donate a pint of blood in Los Angeles and use it in San Francisco. This is what the committee has in mind for Illinois.

The committee recommends that samples of blood be sent to various laboratories to be used as a check on the laboratory's ability to cross match, determine the rh factor, etc.

This is an active committee, and one which serves the membership of the Society concretely. There are eight members, three from Cook County, and five from downstate Illinois.

2) Committee on Cancer Control. This Council committee works in close cooperation with the Illinois Division of the American Cancer Society. When new scientific courses are presented for Illinois physicians, the committee approves the project. When the Illinois Division of the American Cancer Society installed an exhibit at

the Museum of Science and Industry, the working model was brought to the Council meeting for a "pre-view" check and official approval. The cooperation is a simple and easy working arrangement, to be expected when men such as Dr. John A. Rogers of the Illinois Division and Dr. Warren H. Cole as chairman of the committee are the representatives involved. The Society is most fortunate, and so is the Division, but the residents of the State of Illinois are the ones who benefit the most from the constructive work and constructive planning of the Committee and the Division.

County medical societies can contribute materially to the success of the program by working with representatives of the American Cancer Society and by participating in the local county activities of the Illinois Division.

(3) Committee on Cardiovascular Disease This committee is comparatively new. Its function is similar to that of the Committee on Cancer Control, in that it cooperates and works in an advisory capacity with the Chicago Heart Association and the Illinois Heart Association. The Illinois Heart Association has scheduled meetings throughout the state for the physicians in the various areas; it has cooperated with the Postgraduate Education Committee in planning meeting dates to avoid area conflicts; it has used members of the Illinois Medical Society as the scientific faculty in presenting these sessions.

The interest of this committee has grown during the few years it has functioned. In January of 1953 the chairman, Dr. Warner Newcomb, reported that the Chicago and the Illinois Heart Associations have approved a proposed amendment to the Workmen's Compensation Law in Illinois. The law is based on the assumption that accidents and disease are properly regarded as one of the costs of industry, and that therefore, employers can be expected to compensate employees for disabilities incurred in their firms. A special problem arises from the fact that the law separates partial and total disability, and provides much higher rate of compensation for total disability. The law makes the employer liable for the total condition of the employee after the injury; or in other words, if the injury in question, plus prior disabilities incurred even under another employer, renders the employee totally disabled, the second employer must pay the compensation set for total disability. Obviously this keeps employers from hiring a person with any previous impairment.

To overcome this for already handicapped persons, the amendment recommended extends this so-called "second injury provision" to those who, for example, have a cardiac disability at the time of employment, and then suffer an injury, of which in combination with the cardiac condition, renders the employee totally disabled. Thus the employer of a man with a pre-existing cardiac condition is not penalized for whatever effect this cardiac condition may have on his own compensation liability. The Council approved the report of the committee, and made all Society facilities available to the group to assist in any way possible.

The interests of the committee are varied and its work of importance to the members of the profession as well as to the residents of the state.

(4) The Committee on Constitution and By-Laws. The Constitution and By-Laws of the Illinois State Medical Society is ever changing. The last general revision took place in 1941, but the growth and needs of the Society have necessitated additions, deletions and changes at nearly every annual meeting of the House of Delegates. The Constitution may be amended "by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall not be acted upon before the day following that on which it was introduced. The By-Laws may be amended in like manner.

The Committee receives suggestions from time to time from the membership, from the Council, from the secretary's office, etc. The material is put into proper form for presentation to the House of Delegates for acceptance or rejection. Illinois has had some special problems to adjust from time to time. The Constitution required that all members be licensed to practice in the state; in order to accommodate full time employees of the American Medical Association, and also physicians not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, special sections were added to the Constitution to provide for these cases.

When the Benevolence Fund was established provisions had to be made in both the Constitution and By-Laws to safeguard the fund itself and the recipients. The list of constitutional

committees has been increased from time to time, the action in some cases being debated at length on the floor of the House. The last two committees to be added were the Committee on Medical Testimony and the Grievance Committee.

Copies of the Constitution are available for members desiring them. The latest changes, resulting from action taken by the 1953 House of Delegates, have been incorporated, and the copy has been sent to the printer. New Constitutions and By-Laws should be ready for distribution by October 15th. They will be mailed to all county and branch society officers.

The County Medical Societies throughout Illinois should appoint committees to study and become familiar with the Constitution and By-Laws of the State Society. There should be no points of fundamental difference between the constitutions of the county societies and that of the state body. Action should be taken at the county level whenever necessary, as action is taken periodically at the state level to incorporate and comply with changes made in the Constitution and By-Laws of the American Medical Association.

A better knowledge of the Constitution and By-Laws would give members of the average county medical society information as to what is done for them, and what they can do for their state medical organization. The Committee on Constitution and By-Laws helps to form the policies and to strengthen and develop the frame work of organized medicine.

Future chapters of "Know Your Society" will contain information relative to the remainder of the Council committees and their activities.

BLEEDING ULCER

The bleeding ulcer patient should not be starved or placed on cracked ice and morphine. As suggested by Rossett, our routine is to feed a high protein, pureed diet in small amounts every two hours during the day with sodium luminal, grains 2 every 4 to 6 hours. Food is withheld only if vomiting is present. Antacids in the form of calcium carbonate and magnesium oxide as powders in 200 c.c. of milk are given every two hours through the night during the period of bleeding. Five days after the termination of all bleeding the patient is allowed up. During these five days he is fed a mixture of aluminum hydroxide gel and milk of magnesia every two hours during the night in the amount necessary to effect neutralization of the gastric contents. When he is allowed up, he is given a bland diet with milk of magnesia and aluminum hydroxide gel as outlined in the treatment of uncomplicated peptic ulcer. In general, if a person is past the age of 45 years and has bled massively once, elective operation is suggested. Patients under 45 years of age with two massive bleeding episodes are advised to have surgery. At times, because of occupation and geographical location, we recommend surgery under the age of 45 on the basis of one massive bleeding episode. *Roger F. Metcalf, M.D., The Management Of Peptic Ulcer Disease. J. Maine M.A., July 1953.*

CORRESPONDENCE



DEDICATE PSYCHIATRIC RESEARCH LABORATORY

The dedication of the Thudichum Psychiatric Research Laboratory at the Galesburg State Research Hospital at Galesburg, Illinois will take place at that Institution on October 17, 1953. Dr. Graff, Superintendent of the Hospital, will be Chairman during the morning session that will begin at 10:30 A.M. Governor William G. Stratton and Dr. Otto L. Bettag, Director of the Department of Public Welfare, and Dr. Percival Bailey, Research Consultant, Department of Public Welfare, will make the opening addresses. Then Dr. D. McK. Rioch, Technical Director, Neuropsychiatric Division, Army Medical Service Graduate School, Bethesda, Maryland, will read a paper on "The brain and consciousness." The afternoon session will begin at 2:30 P.M. and will be chaired by Dr. R. W. Gerard, Consultant in Research, Department of Public Welfare. The speakers will be: Dr. S. S. Kety, Associate Director, in Charge of Research, National Institute of Mental Health, Bethesda, Maryland; Dr. W. Feldberg, Head of Physiology and Pharmacology Division, National Institute for Medical Research, London, England; and Dr. D. Ewen Cameron, Director, Allan Memorial Institute of Psychiatry, McGill University, Montreal, Canada. Their respective subjects are: "Circulation and metabolism of the human brain", "Some aspects of chemical transmission in the central nervous system", and "Extended applications of psychosomatic theory in the senium".

CLINICS FOR CRIPPLED CHILDREN LISTED FOR NOVEMBER

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinic are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The November clinics are:

November 3 — Pittsfield, Illini Hospital

November 3 — Shelbyville, First Methodist Church.

November 4 — Hinsdale Sanitarium

November 5 — DuQuoin, Marshall-Browning Hospital

November 5 — Macomb, St. Francis Hospital

November 6 — Evanston, St. Francis Hospital.

November 10 — East St. Louis, St. Mary's Hospital

November 10 — Casey, High School.

November 10 — Peoria, St. Francis Hospital

November 11 — Joliet, Will County T.B.Sanitarium

November 11 — Alton, Alton Memorial Hospital

November 12 — Springfield, St. John's Hospital

November 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

November 13 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 18 — Evergreen Park, Little Company of Mary Hospital.

November 18 — Springfield (Cerebral Palsy), Memorial Hospital

November 19 — Bloomington, St. Joseph's Hospital

November 19 — Rockford, St. Anthony's Hospital

November 19 — Watseka, American Legion Home

November 20 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 24 — Effingham (Rheumatic Fever), Douglas Township Building

November 24 — Peoria, St. Francis Hospital

November 25 — Aurora, Copley Memorial Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illionis Children'sHospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of services for crippled children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

LECTURE SERIES

The North Shore Health Resort has announced its fourth annual lecture series on Treatment in Psychiatry. All physicians are invited to attend without charge. They are given at 225 Sheridan Road, Winnetka, and all begin at 8:00 P.M. The schedule follows:

Nov. 4, 1953 What is Psychoanalysis?
MARC H. HOLLENDER, M.D., Asst. Prof., of Psychiatry, Chief Psych., O.P.D., Neuropsychiatric Inst., U. of Illinois, College of Medicine; Staff Member, Institute for Psychoanalysis, Chicago.

Dec. 2, 1953 What is Psychotherapy?
RUDOLPH DREIKURS, M.D., Prof. of Psychiatry, Chicago Medical School; Lect. in Education, Indiana U., Gary Center; Med. Dir., Community Child Guidance Centers of Chicago; Pres., Amer. Society for Group Psychotherapy and Psychodrama; Editor, Amer. Journal of Individual Psychology.

Jan. 6, 1954 The Role of a Psychiatrist in a Hospital HOWARD P. ROME, M.D., Head, Section of Psychiatry, Mayo Clinic, Mayo Foundation; Graduate School of Medicine, University of Minnesota.

Feb. 3, 1954 The Use of Shock Therapy and Psychosurgery LOTHAR B. KALINOWSKY, M.D., Att. Psychiatrist, N. Y. State Psychiatric Institute and Hosp., Associate Attending Neurologist, Neurological Institute.

Mar. 3, 1954 The Role of the Family in Emotional Disorders JULES HENRY, Ph. D., Assoc. Prof., Anthropology, Washington U., St. Louis, Mo.; Member, Com. on Child Development, National Research Council; Assoc. Editor, Amer. Jour. of Orthopsychiatry.

Apr. 7, 1954 The Treatment of Children

May 12, 1954 (Second Wed.) The General Practitioner and the Discharged Psychiatric Patient KENNETH APPEL, M.D., President, American Psychiatric Association; Professor and Chairman, Dept. of Psychiatry, University of Pennsylvania.

June 2, 1954 How the General Practitioner Can Contribute Toward Healthy Emotional Development DANIEL BLAIN, M.D., Med. Dir., American Psychiatric Assoc.; Clin. Prof. of Psychiatry, Georgetown U., School of Med.; Consult. to U.S.P.H.S., Vet. Adm., Nat. Assoc of Mental Health; Member, Expert Panel on Mental Health, World Health Organization.

RED CROSS DEFENSE BLOOD CENTERS CLOSED

As of August 31, all of the Red Cross Defense Blood Centers throughout the country were closed by order of the Department of Defense. The Red Cross commitments to the Office of

Defense Mobilization and collections for Gamma Globulin can be met by continued collections in Regional Blood Centers.

We at the Red Cross wish to thank you for your cooperation with our Blood Program in the past and feel sure you will stand by to aid us in the future should the need arise.

(Signed) Renee L. Gelman, M.D., Medical Director, Defense Blood Program.

REGULAR ARMY PHYSICIANS MAY NOW RESIGN

Regular offices of the Army Medical Service may resign and leave the service under a new and more liberal Department of the Army policy, according to Major General Silas B. Hays, Acting The Surgeon General of the Army.

Beginning with officers having the longest periods of service, a number will be allowed to resign each month, upon recommendation of The Surgeon General, provided they have met with certain service requirements. Previously, resignations were accepted only in cases of extreme hardship.

According to the new policy, regular officers who have no obligatory commitments to the Army and have served in the Regular Army for a period of three years are eligible for release. However, if they have served for less than eight years, they must accept commissions in the Reserve.

"Even though we expect to lose some officers in the next few months," General Hays said, "we believe the new policy will encourage physicians to enter the Regular Army because they will no longer feel that they will be committing themselves in an indefinite term of service. Actually, I believe that an increasing percentage of officers will find the military service so professionally stimulating and so pleasant that they will make it their career," General Hays concluded.

AN OPEN LETTER TO THE DOCTORS OF THE ILLINOIS STATE MEDICAL SOCIETY

Dear Doctor:

Is your wife a member of the auxiliary to your medical society? If she is not, will you please take your Journal home and ask her to read this letter?

Twenty-five years ago, the Woman's Auxiliary to the Illinois State Medical Society was organized and the following objectives were adopted:

1. To assist the Illinois State Society in the advancement of the prevention of disease.
2. To aid in securing better medical legislation.
3. To do such supplemental work as shall be determined from time to time by the Illinois State Medical Society.

The years have passed and many new objectives have become our goal. Did you know that the auxiliary has contributed more than $35,000.00 to your benevolence fund? We have helped place your magazine, Today's Health, in schools and public offices. Many of our auxiliaries have established Future Nurses' Clubs and Scholarship Loan Funds to assist high school girls to become nurses. We have done a great deal to help alleviate the critical shortage of nurses. We are your best public relations agent. Do you remember how we worked on the "Get out the vote" in the recent political campaign? All of our plans are submitted to an advisory council appointed by your medical society before any action is taken.

We now have 2,309 members but we need your wife, Doctor. We need her idea, her interest and her support. Will you please ask your wife to become an auxiliary member?

Yours sincerely,
RUBY E. KWEDAR
Mrs. A. T. Kwedar
Chairman of Organization of the Woman's Auxiliary to the Illinois State Medical Society.

NEWS OF THE STATE



COOK

Passavant Honors Former Staff Members.—Commemorative Units in the new south Pavilion of Passavant Memorial Hospital have been established to honor former members of the hospital staff. The Commemorative Committee, which will undertake to finance these memorial units to Passavant physicians, deceased or emeritus, is one of the coordinated efforts of the building fund campaign which will be under the direction of Gilbert H. Schribner, Jr. Solicitation for the Commemorative Units will be only among friends and colleagues of the physicians being honored. Those set up thus far are for Marion H. Barker, who, before his death in 1947, was associate professor of medicine at Northwestern University Medical School and one of the founding members of the American Society for the Study of Arteriosclerosis; Arthur H. Curtis, professor of obstetrics and gynecology and former chairman of the department at Northwestern and Passavant Hospital; Sanford R. Gifford, who, when he died in 1944, was professor of ophthalmology and chairman of the department at Northwestern and Passavant; David S. Hillis who, until his death in 1942, was head of the obstetrical department at Passavant and professor of obstetrics and gynecology at Northwestern; Walter H. Nadler, who when he died in 1952, was associate professor of medicine at Northwestern and president of the staff at Passavant and former chief of its medical service.

Passavant Memorial Hospital was established in 1865. Through its affiliation with the medical school at Northwestern, it conducts a continuous program of teaching and research. Every member of its staff is also a member of the Medical School faculty. The new building will provide the Hospital with 100 more beds, and additional teaching beds. It will also provide expansion and improvement of present facilities, teaching and laboratory space with specialized areas for various departments. The cost of the new South Pavilion, including extensive remodelling within the Hospital, will be $3,000,000. More than half of which has already been subscribed by individuals, firms, and foundations.

Chicagoans Attend Neurological Congress.—Among the Chicago physicians attending the International Neurological Congress in Lisbon, Portugal, September 7-12, were Drs. Percival Bailey, Paul C. Bucy, Ben W. Lichtenstein, and Roland P. Mackay, all of whom hold the rank of full professor at the University of Illinois College of Medicine. Dr. Mackay is president of the American Neurological Association, and Dr. Bailey is president-elect.

Personal.—Dr. Edward H. Leveroos, Oak Park, has been appointed to the newly created position of director of the Division of Hospitals and Graduate Education of the American Medical Association's Council on Medical Education and Hospitals. Dr. Leveroos has been serving as associate secretary of the Council on Medical Education and Hospitals. In his new capacity, he will be in direct charge of the council's program of approving hospitals for internship and residency training and of the activities of the council's staff in the program of the Joint Commission on the Accreditation of Hospitals.

New VA Hospital in Operation.—The new twelve story veterans' administration hospital was officially opened, September 1, when nine veterans of four American wars were admitted. The seven million dollar hospital will house 500 patients when operated full scale which will be within ninety days of the opening. It was planned to open one ward at a

time until the unit was filled. Dr. Lee S. Schlesinger is manager of the new hospital. On the grounds of the new hospital are a building with five apartments, a nurses' residence building, and a warehouse and garage structure. The ninth floor of the hospital will be used to house nurses and resident physicians. Ultimately the institution will be staffed with 125 nurses, twenty full time physicians, thirty-five resident physicians, three dental staff members, and three teaching dentists. Formal dedication was planned for September 27.

New Fund for Cancer.—The proceeds of a new trust, set up for the University of Chicago's fight against cancer, were received by the University in August, Dr. Lowell T. Coggeshall, dean of the division of biological sciences recently announced. A. $1,000 check, the first income from the Gordon Stephenson trust of $123,325, was presented to the University for "cancer research and for the treatment and care of persons afflicted with cancer." The late Gordon Stephenson, former operating superintendent of Sears, Roebuck and Company, died January 16, 1952 in an automobile accident. An alumnus of the University of Chicago, he requested that his residuary estate be held in perpetuity and the net income paid to the university. During the first twenty-five years, the university will receive one half of the net income with the other half added to the principal of the fund. At the university, the fund has been named the Gordon Stephenson Fund. Stephenson attended the University from 1919 to 1921. His sister, Mrs. Vincent R. Bliss, Barrington, received her bachelor's degree from the university in 1919.

Richard Ebert Appointed at Northwestern.—Dr. Richard V. Ebert, for the past year Clark professor of medicine at the University of Minnesota School of Medicine, has been appointed professor of medicine at Northwestern University Medical School, effective September 1. Dr. Ebert will also be chief of medicine at the Veterans' Research Hospital.

Franklin C. McLean Retires.—Dr. Franklin C. McLean, professor of physiology and first director of the University of Chicago Clinics, retired with emeritus status at the close of the summer quarter, it was recently announced. Dr. McLean, who served as first director of the University of Chicago Clinics when it was founded in 1927, was director of toxicology for the United States Chemical Warfare Service during World War II. A lieutenant-colonel, Dr. McLean received the legion of merit for his work at Edgewood Arsenal where he was in charge of improving the effectiveness of gases and for his work with the British-American coordination staff on the San Jose project in Panama in testing gas warfare equipment. Dr. McLean was director of the Peking Union Medical College from 1916 to 1920 during the building and organizing of the staff of the medical school and hospital. He served as director of the University Clinics from 1927 to 1932. An observer of the atom-bomb tests at Eniwetok in 1948, Dr. McLean is now deputy chairman of the joint panel on medical aspects of atomic warfare, research and development board of the Department of Defense and Director of the U. S. Air Force project at the University of Chicago. He will remain at the University to continue research on the physiology of the bone, a project now being conducted under a Josiah Macy, Jr. foundation grant. Dr. McLean holds a bachelor's, a master's, a doctor of philosophy degree, and a doctor of medicine degree, all from the University of Chicago.

PEORIA

Personal.—Dr. L. G. Atherton has opened an office at 621 Jefferson Building, Peoria. He plans to limit his practice to obstetrics and gynecology.

SANGAMON

New Executive Director of Memorial Hospital.—George K. Hendrix has been appointed executive director of Memorial Hospital, Springfield. He succeeds Mr. Frank R. Shank, who resigned.

New Officers.—Dr. George B. Stericker was chosen president of the Sangamon County Medical Society recently. Other new officers are: Drs. Thomas Harmon, vice-president; William DeHollander, secretary-treasurer; Jacob E. Reisch and Paul LaFata, board of directors; Kenneth Schnepp and Darrell Trumpe, delegates to the Illinois State Medical Society, and Jacob E. Reisch and J. Marvin Salzman, alternate delegates.

Society News.—Dr. Thomas N. Mier, assistant clinical professor of obstetrics and gynecology, St. Louis University School of Medicine, discussed "Carcinoma of the Cervix" before the Sangamon County Medical Society at a dinner meeting at the Elk's Club, September 3.

VERMILION

Society News.—Dr. Loyal Davis, Chicago, addressed the Vermilion County Medical Society at the Hotel Wolford, September 21, on "Diagnosis and Treatment of Herniated Nucleus Pulposus."

WINNEBAGO

Enlarged Speakers' Bureau.—The Executive Council of the Winnebago County Medical Society has approved an enlarged, well organized Speakers' Bureau to service non-medical groups in the area. Under the chairmanship of Dr. Robert E. Heerens, a list of some thirty titles has been submitted to the membership in the hope that each member will select one or more of the topics for their own presentation. The membership is also urged to submit individual topics should they wish. Once a title has been selected, the Public Relations' Committee plans to assist each speaker in developing suitable visual aids, such as blackboard, charts, slides, and so on, to assist in the visual demonstration. Films will be reviewed for public showing and every effort is going to be made to service the non-medical groups in the area with good, timely health information.

GENERAL

First Rehabilitation Director Named.—Alfred Slicer, Chicago, was appointed the first rehabilitation director of the Illinois State Welfare Department. The appointment was made by Dr. Otto L. Bettag, state welfare director. The Chicago Tribune stated that, under the new program, a coordinator will be appointed at each mental hospital and each patient will be screened on admittance to determine in which direction his capabilities lie. This screening process will continue throughout the patient's hospital stay. Instruction eventually will include both the manual arts and business classes: typing, stenography, and shorthand.

Your Doctor Speaks over FM Station WFJL.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in the series "Your Doctor Speaks" presented by the Educational Committee of the Illinois State Medical Society in cooperation with FM Station WFJL:

William S. Kroger, assistant clinical professor of obstetrics and gynecology, Chicago Medical School, August 20, Emotional Factors in Obesity.

Donald A. Dukelow, consultant in health and fitness, Bureau of Education, American Medical Association, August 27, Health of School Children.

John J. Brosnan, clinical instructor, Department of Surgery, Stritch School of Medicine of Loyola University, September 3, Disturbed Breathing.

Edwin J. DeCosta, assistant professor of obstetrics and gynecology, Northwestern University Medical School, September 10, To Nurse or Not to Nurse.

Saul A. Mackler, assistant professor of thoracic surgery, Chicago Medical School, September 17, Chest Surgery and Cancer of the Lung.

Jerome F. Heinrich, instructor in obstetrics and gynecology, Chicago Medical School, September 24, Role of the Future Mother in Safeguarding Her Pregnancy.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Felix A. Tornabene, Aurora, Mothers Study Club of Elgin, September 23, on First Aid Facts for Mothers.

Robert M. Kark, Oak Lawn Community High School PTA, October 6, on Nutritional Problems of School Children and Their Parents.

Sanford A. Franzblau, West Side Y.W.C.A., October 8, on Relaxation and Modern Living.

Joseph T. O'Neill, Ottawa, Junior Woman's Club in Dwight, October 19, on Child Psychology.

Charles I. Fisher, Loop Center Y.W.C.A., November 2, on Too Tired to Sleep.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Adrien VerBrugghen, Chicago, Whiteside-Lee County Medical Societies at Jul's Danish Farm, Sterling, September 17, on What's New in the Diagnosis and Management of Brain Tumors.

Anthony M. Barone, Chicago, Stock Yards Branch of the Chicago Medical Society in Evangelical Hospital, Chicago, October 16, on Varicose Veins and Venous Thrombosis.

Alex J. Arieff, Chicago, Henry County Medical Society in the Congregational Church, Geneseo, November 11, on Neurology and Psychosomatic Medicine.

Paul C. Bucy, Chicago, LaSalle County Medical Society in the Kaskaskia Hotel, LaSalle, November 12, on Traumatic Injuries to the Brain.

Warren W. Furey, Chicago, Iowa-Illinois Central District Medical Association at the Plantation, Rock Island, November 18, on X-Ray Consideration of Pulmonary Tumors.

Ormand C. Julian, Chicago, Knox County Medical Society at the Galesburg Club, Galesburg, November 19, on Intracardiac Surgery.

Max S. Sadove, Chicago, DeKalb County Medical Society at Bishop McLaren Foundation, Sycamore, November 24, on Recent Advances in Postoperative Care.

Hampar Kelikian, Chicago, LaSalle County Medical Society in the Kaskaskia, Hotel, LaSalle, December 10, on Functional Restoration of the Hand.

DEATHS

Alfred S. Bailey, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died August 25, aged 65. He was vice-president of the staff of the South Shore Hospital.

Arthur J. Chaloupka, Chicago, who graduated at Northwestern University Medical School in 1920, died September 3, aged 59. He was a member of the staff of Ravenswood Hospital.

Charles Ford, Hillsboro, who graduated at Barnes Medical College, St. Louis, in 1904, died April 22, aged 70, of a cerebral vascular accident.

Charles William Gorr, Chicago, who graduated at Rush Medical College in 1903, died June 29, aged 74, of cerebral accident.

Fred Samuel Herrick, Chicago, who graduated at Bellevue Hospital Medical College, New York, in 1884, died June 17, aged 95, of carcinoma of the prostate.

Ross Edward Herrmann, Bradford, who graduated at the University of Illinois College of Medicine in 1934, died April 21, aged 46, of coronary disease.

Charles E. Koons, Creal Springs, who graduated at St. Louis University School of Medicine in 1904, died in an automobile accident in Van Buren, Missouri, recently, aged 75.

Vandy F. Masilko, River Forest, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1900, died August 21, aged 87. He had practiced medicine on the west side of Chicago for more than 50 years.

William C. McGrail, Chicago, who graduated at Loyola University School of Medicine in 1938, died

August 10, aged 43. He was a member of the staff of St. Elizabeth's Hospital.

Harry Nichols, Chicago, who graduated at the University of Illinois College of Medicine in 1913, died August 8, aged 71.

Annie R. Ranes, Chicago, who graduated at Illinois Medical College in 1903, died June 22, aged 82, of chronic myocarditis.

William Henry Schuette, Mason City, who graduated at Hering Medical College, Chicago, in 1904, died April 10, aged 81, of injuries received when struck by an automobile.

Florian E. Schmidt, Chicago, who graduated at Northwestern University Medical School in 1905, died September 10, aged 69. He was medical director of the Chicago Heart Association and had been on the staff of Lederle Laboratories, Inc., and of Armour Laboratories.

Edward G. Tatge, Evanston, who graduated at Northwestern University Medical School in 1925, died September 7, aged 53. He was a member of the staff of Evanston Hospital.

Conrad Benedict Vonnahme, East St. Louis, who graduated at Washington University School of Medicine, St. Louis, in 1905, died June 8, aged 72, of hemolytic anemia.

Maurice Benjamin Wallin, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died May 22, aged 65, of carcinoma of the lung.

CARDIAC ARREST

Cardiac arrest is a situation which may confront any surgeon in the operating room at any time and it is important that he should be able to recognize and treat this condition. It is a surgical emergency for which there is an allowable time of only 3½ minutes during which effective action may be taken. After 3½ minutes, permanent irreversible changes take place in the brain. It is known that 10 to 20 seconds of complete cerebral anoxia produces unconsciousness; 30 seconds produces electroencephalographic wave changes. Vernons described a patient 55 years old who had cardiac arrest for 4 minutes. The heart was started by subdiaphragmatic massage. The patient became conscious the next morning. For the next 10 days he spoke nothing more than a few incoherent phrases. On the 14th day he became restless and began to talk all kinds of nonsence incessantly. By the end of the fourth week he became maniacal and had to be sent to an observation ward. He was there for five months before he became well enough mentally to go to a convalescent home. Nine months after the accident he was examined and found to have a violent tremor of the hands. His speech was slurred and he often repeated words over and over again. He was well enough to start work 11 months after the onset. This is the result of cardiac arrest for a short period of time (4 minutes), so that one can visualize what may happen in cardiac cessation for a longer period. *Thomas F. Keyes, M.D., Cardiac Arrest, Rocky Mountain M.J. Aug. 1953.*

COUNCIL MEETING MINUTES



The regular August meeting of the Council of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, on Sunday, August 16, 1953. The following were present: Lewis, Vaughn, Nicholson, Kirby, Camp, Lundholm, O'Neill, Stone, Hellmuth, Piszczek, Oldfield, Reichert, Hesseltine, Blair, Reisch, Newcomb, Goodyear, English, Montgomery, Fullerton, Hamilton, Hopkins, Cross, Limarzi, Van Dellen, Arthur Taylor, Chas. Allison, John W. Neal, James C. Leary and Frances Zimmer. By proper action, the minutes of the last meeting were approved as mailed to members.

Lewis reports as president, telling of meetings he has attended, and requests for various types of service. Was asked to appoint a liaison Committee to work with the American Legion of Illinois. Committee appointed consisted of Norman Sheehe, Rockford; James Weatherly, Murphysboro; Jacob Reisch, Springfield; and Walter C. Bornemeier, Chicago. Reported recent meeting in Chicago with Chairman of the Council and the Secretary to discuss many Society matters. It is proposed that these conferences be held approximately every six weeks during the fiscal year. Referred to the decision to have a booth at the Duquoin State Fair, which is a big fair in Southern Illinois with an average attendance of more than 350,000. An Auxiliary has recently been formed in Perry County and the ladies will be in charge of this booth at the Fair.

President-Elect Vaughn told of his attendance at the meeting held in the Museum of Science and Industry, at which time Earl H. Blair was honored by the Freedom Organization for his work in the field of Civil Defense. He also referred to the time necessary to fill out the usual insurance reports, stating that simpler forms are needed and should be considered by this Society, as has been done successfully in some other states.

There was a general discussion on the subject of medical care of veterans, and the ever increasing percentage of patients in V.A.F. cared for who have non-service connected disabilities. Secretary referred to a meeting to be held in Chicago, September 1, sponsored by the A.M.A. to discuss this matter. The Liaison Committee appointed by Lewis was selected to act as official representatives from this Society.

Secretary gave his supplementary report, stating that since his last report of the operation of the Illinois Physician Placement Service, 22 additional Illinois communities have been supplied with physicians. Secretary passed out packet of information sent to physicians asking for aid in seeking locations, and one sent to the communities asking for a doctor. A third packet of informative material sent to new members was also shown to the members of the Council. Secretary suggested possibility of asking three or more component society officers to attend each meeting of the Council so they will be better informed of the work the Council does at these sessions. The Council went into executive session to receive a committee report. After arising from executive session, Hopkins reported as Chairman of the Committee on Medical Service and Public Relations, telling of a meeting of this Committee the previous day. It was recommended that the Council approve the rewriting of two brochures, — the insurance pamphlet and the one pertaining to rural medical services. The Committee likewise has had a new outline of medical public relations work prepared, this has been mimeographed and sent to each of the members. After necessary revisions, the Committee would like permission to have this printed and sent to all component societies, and Public Relations Committees. Motion, Reichert-Montgomery, that the proposal be approved. Motion carried. Neal stated that the final report of the legislative work should be completed

within a period of ten days. He briefly told of a number of bills passed by the legislature, and some which had been introduced but not approved.

Leary discusses medical public relations, and stated that he would like to prepare for each issue of the Illinois Medical Journal, a section devoted to Medical Public Relations. This was approved and will be published in the October Journal for the first time.

English discussed the coming post graduate conferences now being arranged, and he suggested that for each of these conferences, the Councilor be scheduled to give a short presentation of some phase of Society work, such as the physician placement service, work of the rural medical care committee, and especially the joint loan fund sponsored by this Society and the Illinois Agricultural Association. Several other subjects would likewise be of interest, and he suggested that the Secretary help in the procurement of the desired data to be sent to the individual Councilors. Motion, Lundholm—Vaughn, that this be scheduled and the Secretary aid in preparing the desired material. Motion carried.

Piszczek discussed this proposal and thought it a good thing to get informative data to physicians. Blair reported as Chairman of the Educational Committee, telling of present activities. Told of Committee considering sponsorship for TV shows, but makes no recommendation at this time. Referred to increasing postal rates which will increase the expense in sending out Health Talk and other material. Committee believes it advisable to use a clipping service again, as none has been used for the past two or three years. By proper action the Committee was authorized to use a limited clipping service for a test period of one year. Hellmuth reported on the Post Graduate Committee efforts to improve P.G. services throughout the state. Have used facilities of teaching hospitals and medical schools to get the desired speakers. The Committee believes it best to try a new plan in having the conferences at local hospitals, perhaps using patients or dealing with pathology or surgery. More time to be devoted to question and answer periods. Although the attendance may be smaller, he believes the educational value will be stepped up. Tells of desired budget for these conferences — part of which is to be used for the survey work to determine what the physicians really want along the line of home area post graduate service. Believes a field man should go out to determine from county societies exactly what is needed and wanted. Would like to schedule a number of larger conferences, then perhaps as many as 30 smaller ones during the present fiscal year. There was a general discussion of this subject, with some variance of opinion evidenced. Kirby has attended all but one of the conferences given last year, and he believes we should endeavor to give the best in education to the greatest number of physicians, and give them what they want. Referred to the popularity of the Springfield Conference where the panel system was used last April. Secretary tells of his cross section survey through a questionnaire sent to physician-members in every county outside of Cook. Excellent response and replies still coming in. Secretary was instructed to submit a report of the findings to accompany the minutes of this meeting. Further discussion by English, Hamilton, Fullerton, and Hesseltine. Goodyear attended four of the larger conferences the past year and it was his opinion that the panel method was best approved. Hamilton said it is time to begin planning for the series to be conducted during the fall, and perhaps early winter. The Finance Committee approves the scheduling of conferences to begin early in the fall. The budget will be considered by the Finance Committee and a report given at the next meeting. Cross stated that the facilities in the four regional state health offices may be used, and the personnel will be glad to render any possible assistance.

Montgomery reported on the meeting the previous evening of the Medical Advisory Committee to the Illinois Public Aid Commission. Several visiting physicians, members of their local county Advisory Committees were present and participated in the deliberations. Efforts are being made to get drugs of $1.00 or less given at home or office visits, passed without itemization. Arrangements are now being made for representatives of the Medical Advisory Committee to meet with the officials of the State Commission to see that the many problems pertaining to the medical care of I.P.A.C. clients are thoroughly understood. This will no doubt be done before the next meeting of the Council, and a more thorough report should be given at that time. O'Neill told of some official visits recently made, dedication of new Physicians' Clinic at Sterling — presentation of three Fifty Year Club membership certificates and emblems, etc. Oldfield told of meetings held in Aux Plaines Branch of the C.M.S., with prominent speakers on the programs; also told of insurance plan in his Branch whereby a check for $200.00 is presented to the survivor within 24 hours after the death of a member.

L'marzi reported as Chairman of the Scientific Service Committee, which is now rearranging the speaker's list. Notices in Illinois Medical Journal and thirteen county Society Bulletins requesting additions to this speakers list. Seventeen members of one downstate clinic group offered their services. Meetings for a number of component societies are now being arranged for the coming months. A committee conference will be held during September to formulate plans for the work for the fiscal year. Secretary gives report for the Medical Benevolence Committee showing 31 beneficiaries at this time, 11 men and 20 women receiving benevolence vouchers each month. Cross gave interesting report of the activities of the State Health Department. Referred to legislative enactments pertaining to health as passed by the last Legislature. Several new responsibilities were given to his Department.

Reisch told of the increasing popularity of the Society Booth at the Illinois State Fair. This obviously was more popular this year than ever before. Better arrangements this year, and it was necessary to

keep the booth open also for the evenings during the Fair, this requiring three shifts of attendants, but the Woman's Auxiliary willingly took care of the requirements. Newcomb stated that the Illinois Heart Association has requested permission from the Committee on Cardiovascular Disease to hold teaching clinics in various parts of the State dealing with diagnostic problems in cases of rheumatic fever and congenital heart disease. The Committee insisted that permission first be received from the local county medical societies. The group is willing to work with Dr. Hellmuth and his Post Graduate Committee to avoid conflicts in dates for these sessions. Newcomb recommended that Joseph J. Grandone, Gillespie, be added to the Post Graduate Education Committee as representing the Sixth Councilor District. Chairman Stone immediately made this appointment and directed the Secretary to so notify Dr. Grandone. Motion (Newcomb—Blair) that the Council approve teaching clinics on rheumatic fever and congenital heart disease to be conducted by the Illinois Heart Association with the consent of the local county medical society and in cooperation with the Committee on Postgraduate Education. Motion carried.

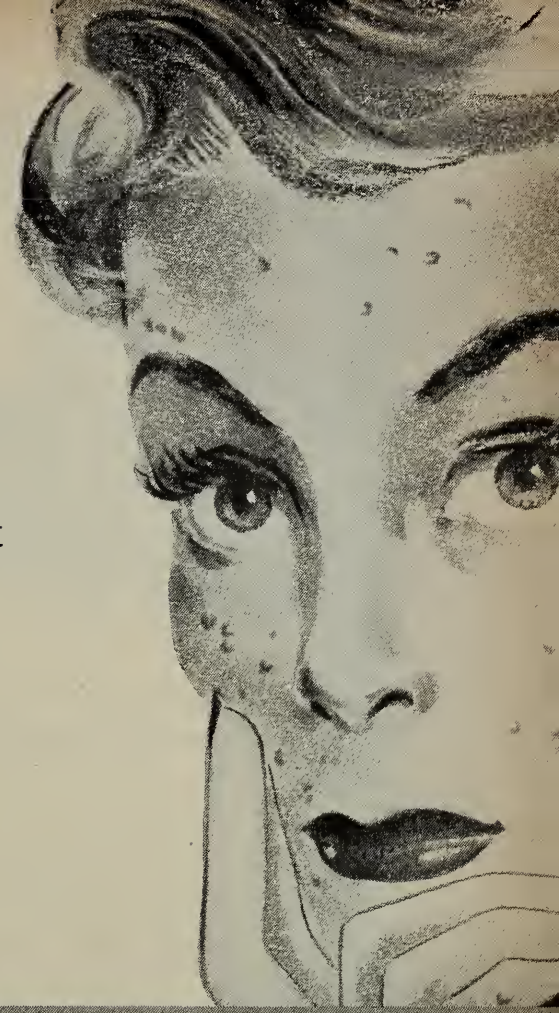
Goodyear told of the massive inoculation program with gamma globulin for 21,000 children up to age of 10. Decatur and Macon County has recently had an emergency poliomyelitis situation. With the cooperation of the Civil Defense Committee, Macon County Medical Society, Chamber of Commerce, the Service Clubs, etc., this was a well organized program carried out most satisfactorily. Several discussed the gamma globulin program as carried out in Macon County. Dr. Cross was there and was most favorably impressed with the cooperation given in carrying on this important work. Fullerton stated that we was working on plans for the Society exhibit at the DuQuoin State Fair, approved by the Council. He aided in the organization of the Perry County Woman's Auxiliary which will be on hand during the entire fair to look after the booth. Believes this will be an excellent public relations venture. Hamilton called attention to the recent accident received by Dr. George F. Lull, Secretary-General Manager of the A.M.A., and a member of this State Society. Suggested that the Secretary be instructed to send a letter of best wishes to Lull with flowers.

Motion (Blair-Vaughn) that Secretary be instructed to send flowers and letter to Dr. Lull at the Henrotin Hospital. Motion carried. Vaughn suggested that official recognition be given to Earl H. Blair for being honored for the fine work he has done along the lines of civil defense. Motion (Hamilton-Vaughn) that this be done. Motion carried.

Limarzi referred to a letter recently received stating that all Red Cross Blood Banks will be closed by order of Civil Defense; the Red Cross desires to thank physicians for their fine cooperation in this worthy project. Suggests that this announcement be published in the Illinois Medical Journal, as it will also appear in the Bulletin of the C.M.S.

Reichert tells of the many questions asked about gamma globulin, many wondering why it is not available for all children desiring it. Hospitals are filled with people suspected of having poliomyelitis, without a definite diagnosis. Many more suspects than real cases of polio—nurses overworked when they could be of greater service in accident cases and other emergent conditions. Although many articles have appeared in our journal, but he is inclined to believe that too few physicians read these articles.

List of Emeritus and Past Service-Retired membership candidates appeared in the minutes for the meeting, all approved by their respective component societies. Motion (Fullerton-Hamilton) that they be so elected. Motion carried. Motion (Reichert-Fullerton) that the bills as audited by Finance Committee, be approved. Motion carried. Chairman Stone reminded the members that the next regular meeting of the Council is scheduled for October 18, 1953. Council adjourned at 2:00 P.M.



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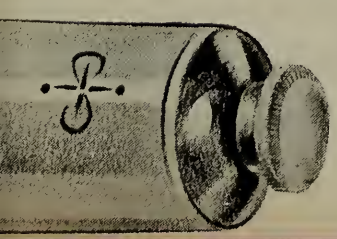
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BOOK REVIEWS



GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY. By Francis Heed Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School. Consulting Surgeon, Wills Eye Hospital, Philadelphia. New, 5th Edition. 488 pages with 281 figures and 26 color plates. Philadelphia and London: W. B. Saunders Company, 1953. Price $7.50.

This is the second edition of this widely used textbook to be prepared by Doctor Adler; the previous three were under the direction of the original author, Doctor Sanford R. Gifford, who died in 1944.

In the Fourth Edition in 1947 there had been a shortening of the material on technics of refraction and operations and more emphasis was laid upon the relation of the eye to general medical and neurological conditions. The Fifth Edition gives only the general indications for operative procedures and omits the details of the various surgical technics. The current edition has an enlarged section on the medical conditions as related to the field of ophthalmology. This edition has many new and better illustrations — this reader would like to see even more of the colored photographs and drawings.

High recommendation as a reference and as a text book is given this well written, well printed, authoritative, remarkedly current book. It is and will be a favorite of undergraduate medical students; it is an excellent reference for the general practitioner and the section on ocular disorders as a result of diseases of the central nervous system and of general disease should hold a strong interest for consultants.

L. P. A. S.

MODERN CONCEPTS IN MEDICINE, by Julius Jensen, Ph.D., M.R.C.S., L.R.C.P. C. V. Mosby Co., St. Louis. $11.50.

The general principles underlying new medical knowledge is too often obscure. This book has been written to facilitate the understanding of internal medicine. Too often the busy student does not take time to investigate the past in his reading of modern medical literature, and this should be done to give a better understanding of the developments throughout the years which are so closely related to the current lines of thought concerning present day consideration of many diseases.

The first part of the book discusses the development of modern medical concepts, cellular activity and the principles of adaptation. The second part, the essential processes of adaptation, in which chapters are devoted to metabolism, fluid balance, electrolyte balance, hydrogen-ion concentration, regulation of temperature, the immune reaction, and neoplasia.

The third part on structural facilities in support of adaptive processes, in which are considered in order, the gastrointestinal tract, the liver, facilities for final stages of metabolism, the kidneys, locomotor facilities, structural responses to the immune reaction and related stressors, and the transportation system.

The fourth part of the book deals with cybernetics, a term which the author explains and justifies, although it is not found in the current unabridged or medical dictionaries. The author states that the most important advances in knowledge in medicine, will be made by men who know chemistry, physics and mathematics. These fields are concerned with the stimulation and control of activity and function. The relation of these fields to studies which are beyond the immediate scope of medicine are mentioned, and explained.

In succeeding chapters of this part of the book, the author deals with enzymes and enzyme transportation systems, vitamins, the endocrines, and the nervous system. The final chapters deal with the coordination of the

(*Continued on page 52*)

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(1) Cheadle—*Artificial Feeding and Food Disorders of Infants.* Sixth Edition (1906)

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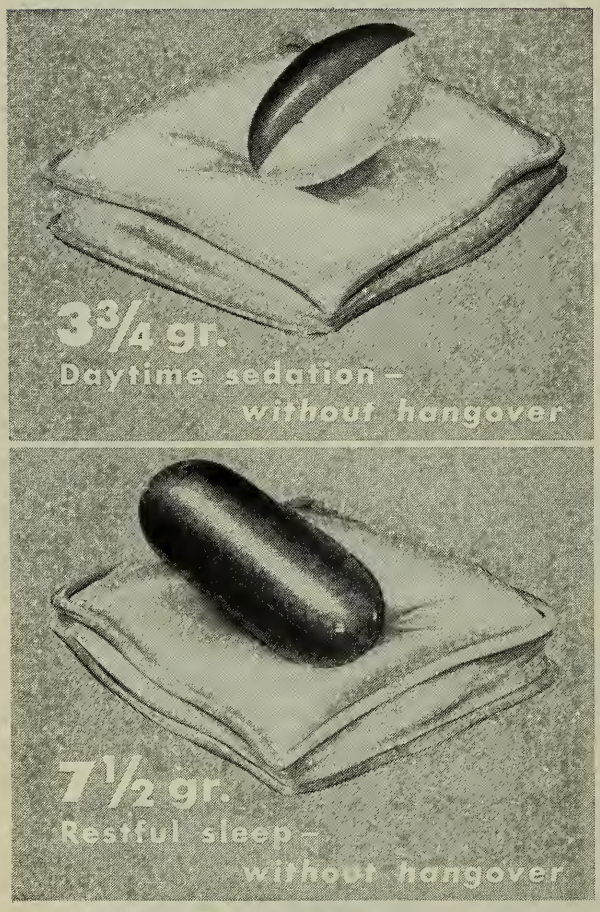
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BOOK REVIEWS (Continued)

adaptive processes, and the western man and adaptation.

The book is well written, the format is excellent, and there are 631 pages in it. Many of the basic principles underlying modern medical concepts, are well discussed in the volume.

New and Nonofficial Remedies—1953. The book is published by the J. B. Lippincott Company, Philadelphia, and it is a most practical book for physicians, students or those interested in pharmacology.

This interesting and practical book is published annually under the direction of the Council on Chemistry and Pharmacy of the American Medical Association. This book differs from many other modern pharmacologies or drug encyclopedias, in that every new product is accepted for the current issue after satisfactory evidence in support of claims for the product has been submitted.

Previously, the editions of New and Nonofficial Remedies has consisted of two principal sections. The first containing general statements and monographs describing actions, uses and dosages for the various drugs. The second section contained tests and standards for Council accepted drugs for which official standards were not available.

Beginning with the 1953 edition, these two sections will appear as separate volumes; New and Nonofficial Remedies, and Tests and Standards for New and Nonofficial Remedies. Each year the Council on Pharmacy and Chemistry of the American Medical Association reviews and revises general statements and monographs. Those articles no longer considered useful, are eliminated. Much information has been made available to the physician in giving the actions, uses, limitations and dosage of acceptable and reliable new drug products.

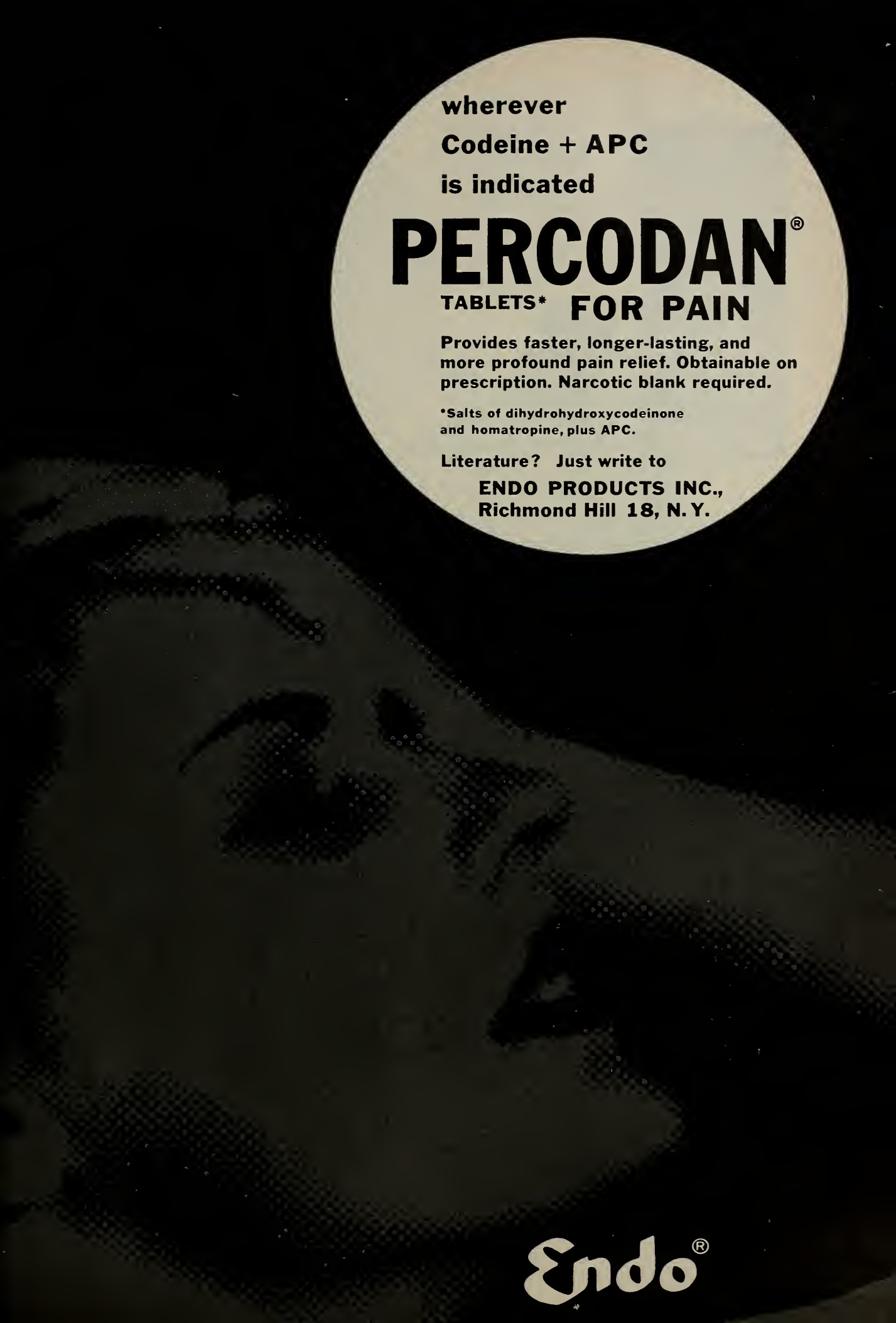
Stedman's Medical Dictionary. Printed for the Williams and Wilkins Company, Baltimore, Maryland; price $11.50.

In keeping with the ever increasing developments in medical science, it was deemed advisable to publish this 18th edition of Stedman's Medical Dictionary in 1953. The book was edited by Norman Burke Taylor, V.D., M.D., etc., University of Western Ontario, in collaboration with Lt. Col. Allen Ellsworth Taylor, D.S.O., M.A. Several thousand words and nearly 600 illustrations, most of which are original drawings, have been added to the present new edition.

Stedman's has always been a popular medical dictionary, and there is no reason to believe that this new edition will not be as popular as have the many previous editions. The book is up to date in accordance with the many medical advances of recent years.

Composed of 1561 pages, with many hundreds of illustrations, excellent format making it easy to use, the reviewer predicts an increasing popularity for the book, one which would be a welcome addition to any medical library or office.

(*Continued on page* 56)


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BOOK REVIEWS (Continued)

MODERN DRUG ENCYCLOPEDIA. Published by Drug Publications, Inc., 49 West 45th Street, New York 36, N.Y. Price, with 3 year supplementary service, $15.00.

Edited by Marion E. Howard, M.D., F.A.C.P., Associate Clinical Professor, Department of Medicine at Yale University Medical School. This is the fifth edition of the book. The last edition was published three years ago, and with the many advances in Medicine during this period, the book has been revised and brought up to date. The author states that this edition has been completely rewritten and reset, and it contains descriptions of 1475 newly introduced drugs, biologicals and allergens so that it will keep abreast of important therapeutic advances.

In addition to the general index and therapeutic index, there is a manufacturers' and distributors' index, which makes it easier to identify many of these newer products by the busy physician. Frequently the physician knows only the manufacturer of a product and may have momentarily forgotten its name, and with a list of the leading pharmaceutical manufacturers of the nation listed, the product can be easily identified.

In addition to the name of the product, there is a general description, giving the complete formula for tablets, liquids or other products; then in detail, its action and uses. There are 1431 pages in the book, with the thousands of pharmaceutical products listed in alphabetical order, arranged to make it easier for the physician to obtain the information desired in a short period of time.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SEXUAL BEHAVIOR IN THE HUMAN FEMALE: By Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, Paul H. Gebhard, Research Associates; and others on the Staff of the Institute for Sex Research, Indiana University. Foreword by Robert M. Yerkes and George W. Corner. 842 pages — 151 charts — 179 tables — four illustrations. Philadelphia and London: W. B. Saunders Company, 1953. Price $8.00.

MAY'S MANUAL of the DISEASES OF THE EYE, For Students and General Practitioners: Twenty-First Edition Revised and Edited by Charles A. Perera, M.D., Associate Professor, College of Physicians and Surgeons, Columbia University, New York; With 378 illustrations, including 32 plates, with 93 colored figures. Baltimore, Williams and Wilkins Company, 1953. Price $6.00.

SURGICAL PATHOLOGY: By Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pa-

(*Continued on page* 58)



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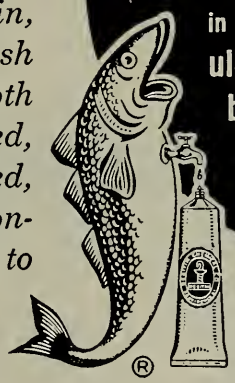


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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J. M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives Pediat. 68:382, 1951.

BOOKS RECEIVED (Continued)

thology, Washington University School of Medicine; Surgical Pathologist, Barnes Hospital and Affiliated Hospitals, St. Louis. With 913 illustrations. St. Louis, The C. V. Mosby Company, 1953. Price $14.50.

PEDIATRICS: By L. Emmett Holt, Jr., Professor of Pediatrics, New York University College of Medicine; Director, Children's Medical Service, Bellevue Hospital, New York City; and Rustin McIntosh, Carpentier Professor of Pediatrics, Columbia University and Director of the Pediatric Service in the Babies Hospital, New York City. Twelfth Edition. Appleton-Century-Crofts, Inc., New York. Price $15.00.

MANIC-DEPRESSIVE DISEASE, Clinical and Psychiatric Significance: By John D. Campbell, M.D., Diplomate, American Board Psychiatry and Neurology; Fellow, American Psychiatric Association; Attending Psychiatrist, Georgia Baptist Hospital, Atlanta. Philadelphia and London; J. B. Lippincott Company. Price $6.75.

THE HEART BEAT, Graphic Methods in the Study of the Cardiac Patient: By Aldo A. Luisada, M.D., Associate Professor of Medicine, and Director, Division of Cardiology, The Chicago Medical School, under a Teaching Grant of the National Heart Institute, U.S. Public Health Service; Associate Visiting Physician (Acad. Staff) and Chief of Cardiac Clinics, The Mount Sinai Hospital of Chicago; Chief of Service and Cardiologist, LaRabida Hospital for Rheumatic Children; With 311 illustrations. Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers. Price $12.00.

TEXTBOOK OF GYNECOLOGY: By John I. Brewer, B.S., M.D., Ph.D., Professor of Obstetrics and Gynecology, Northwestern University Medical School; Chief of Gynecology and Obstetrics, Passavant Memorial Hospital, Chicago. The Williams and Wilkins Company, Baltimore, 1953. Price $10.00.

HANDBOOK OF DIFFERENTIAL DIAGNOSIS: By Harold Thomas Hyman, M.D., Author of "An Integrated Practice of Medicine". Philadelphia and London. J. B. Lippincott Company. Price $6.75.

LIVING WITH A DISABILITY: By Howard A. Rusk, M.D., and Eugene J. Taylor, in Collaboration with Muriel Zimmerman, O.T.R., and Julia Judson, M.S., The Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center. The Blakiston Company, Inc., Garden City, New York, 1953. Price $3.50.



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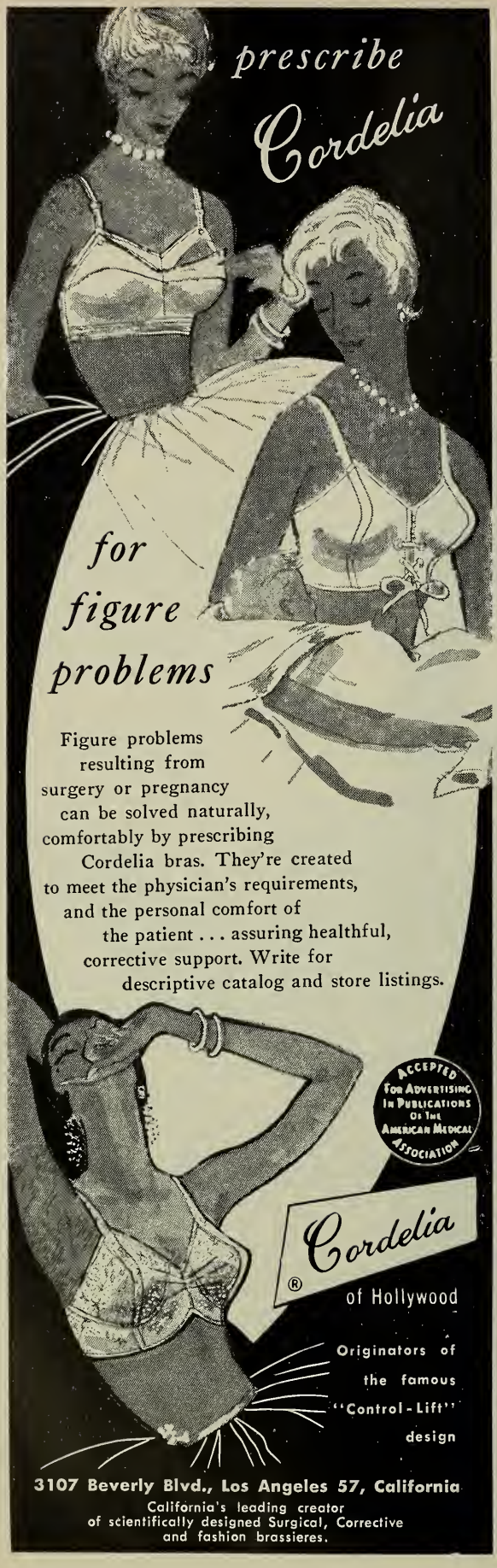
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WHAT DO PATIENTS THINK ABOUT FEES?

Harried as they have been by maliciousness and inaccuracies in many magazine articles, members of the medical profession are apt to overlook the many favorable discussions which appear in national magazines—especially those on medical economics and the relationships of the patient to his doctor. Among these is a piece in the July *Woman's Home Companion,* entitled, "How Much Should Your Doctor Charge?"

We recommend it to every physician, not only because of its sympathetic treatment, but because most, if not all of us, can benefit our own practice through reading it.

While the article gives sound advice to the patient who is concerned about what his medical bill will be, it also reveals interesting data on patient attitudes which may help the physician meet the layman half way in the problems of medical economics.

It cites, for instance, a study made by the Mecklenburg North Carolina Medical Society. Referring to Dr. David Goe Welton, president of this society which surveyed patient attitudes in Charlotte and several nearby towns, the article says:

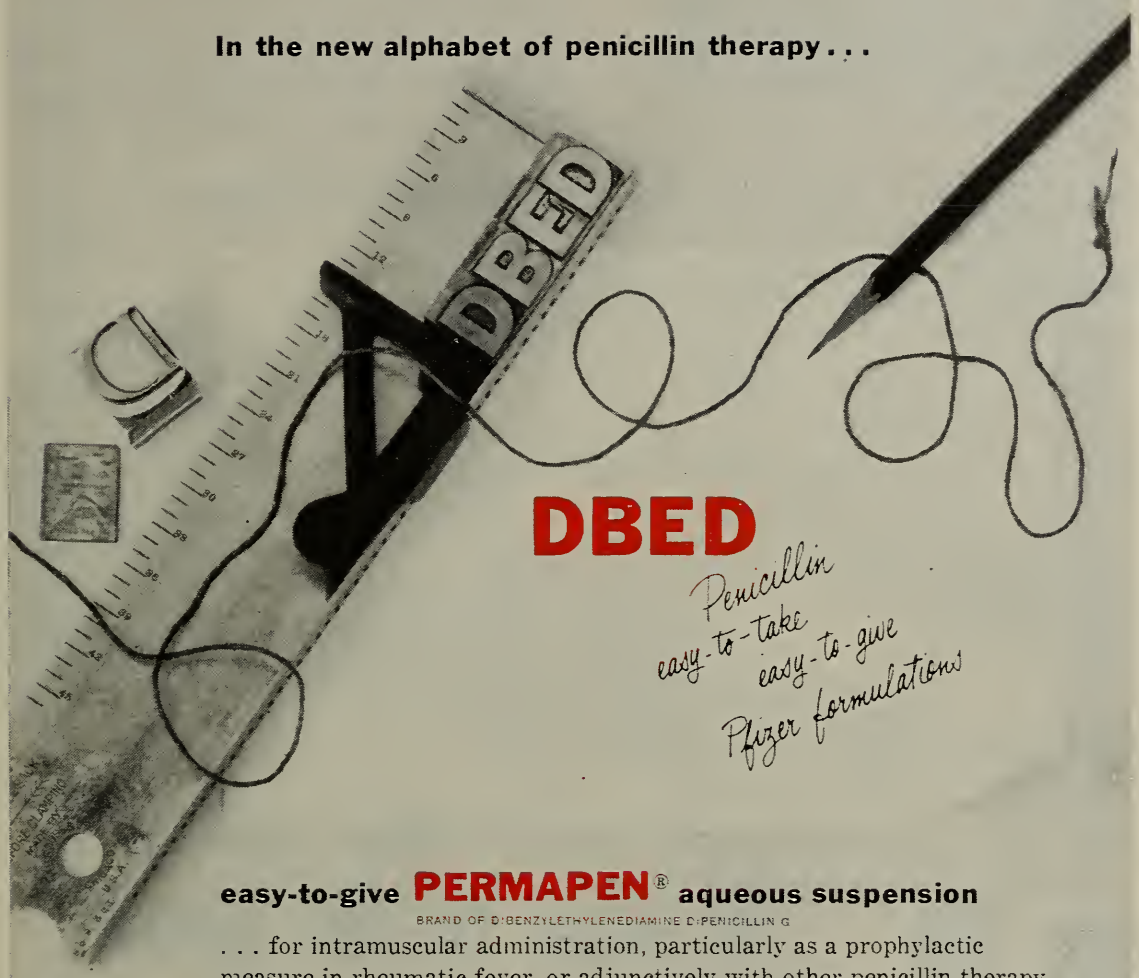
"He knows, for example, that more than half the people queried were so awed by medicine's ultraprofessional aura that they thought it was improper to ask in advance what the doctor would charge. He also knows that despite this bashfulness, eighty per cent of the people would like itemized doctors' bills."

On the other hand, Edward Whitman, writer of the story, says: "I was surprised to discover, as I called on many doctors in many cities, that often they, even more than the patients, are the bashful ones. They get tongue-tied when they talk about money. That ultraprofessional aloofness, even that wave of the hand and the words, 'I never discuss fees—see my secretary,' often mask timidity. Such a doctor has not matured socially; he still feels guilty about charging a fee at all.

" 'The average student goes into medicine because he wants to be a humanitarian,' said Dr. H. Gordon MacLean, of Oakland, California, 'but it doesn't take him long to find out that he has to make a living. If the thought that a

(*Continued on page* 66)

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FEES (Continued)

doctor is a dedicated humanitarian is deeply imbedded in his mind, there is a source of conflict that later in life will make it difficult for him to discuss fees.' "

Mr. Whitman has more to say on other aspects of the fee problem, so we repeat our recommendation that every physician should read this excellent article. In the foregoing excerpts, however, we have selected much of what he apparently regards as fundamental to the monetary problems in patient-physician relationships. The hesitancy by the persons on both sides of the doctor's desk to discuss fees almost insures that neither will be fully satisfied. This is bad for the doctor; it is bad for the patient.

The display of the A.M.A. plaque inviting patients to discuss fees, the itemization of statements, and the other devices to ease the money-caused tension between physician and patient may be important. Basically, however, they are probably but manifestations, where used, of the doctor's willingness to face up to the facts of life. Since the matter of money has loomed large as a source of patient dissatisfaction, it behooves us all to take the initiative in learning what the patient's problem is and to try and meet it squarely.

We can think of no better start than reading Mr. Whitman's article, in which he does such a good job of presenting to the public our side of the picture. *The Journal of the Kentucky State Medical Association Aug., 1953.*

FAINTING OR VERTIGO

Faulty cerebral hemodynamics is thought to cause the rare syndrome of fainting or vertigo, with or without convulsions, after paroxysms of coughing and is known as tussive syncope.

A form of symptomatic epilepsy is at least partly responsible, believes Desmond S. O'Doherty, M.D., of Georgetown University, Washington, D.C., who cites abnormal encephalograms in all of 5 recent cases affecting 4 elderly men and 1 woman. An additional factor is probably some form of cortical dysfunction.

The condition is usually associated with pulmonary emphysema and chronic bronchitis with cough. Pulmonary emphysema builds up intrathoracic pressure. The added stress of cough-



ing impairs cardiac output and produces cerebral congestion and anoxia.

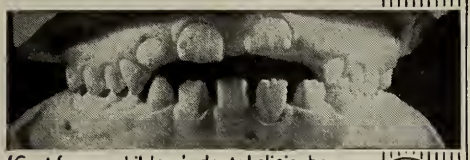
The affected group presumably also have hypersensitive vascular reflexes. The stimulus comes from vagal sensory end organs in the larynx or bronchi but may originate in the esophagus, so that syncope results from swallowing. *Desmond S. O'Doherty: Tussive syncope and its relation to epilepsy. Neurology 3:16-21, 1953, as abstracted in Journal-Lancet, September 1953.*

From the evidence now available, there is no indication that shortly there may be a significantly decreased need for beds for tuberculosis patients. Comm. on Therapy, Am. Rev. Tuberc., May, 1953.

The family physician is still the greatest source of new cases (of tuberculosis); next comes the contact group. The routine examination of admission to general hospitals is proving a valuable source of case-finding. Not only is it a more productive source than the mass surveys of whole communities, but it is of particular value to the medical profession, which is already the most important source of new cases. G. J. Wherrett, M.D., Canadian J. Pub. Health, May, 1953.

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INCIDENCE OF THROMBOEMBOLISMS

The incidence of massive pulmonary embolism is much greater for individuals with early thromboembolism, probably because sufficient time does not elapse for the long clot to become firmly attached to a peripheral vein wall.

Shock, hypotension, or relative hypotension precedes nearly all early episodes of postoperative pulmonary embolism, finds Harry A. Davis, M.D., of the College of Medical Evangelists, Los Angeles. Thromboembolisms occurring in the lung within forty-eight hours after an operation, accidental injury, or hemorrhage have an extremely rapid course and a high incidence of massive embolic occlusion of the main pulmonary artery.

The patients are usually at least 50 years of age. The incidence is higher in elderly persons because of the difficulty in reestablishing normal blood flow after hypotension and also because of the more frequent saccular dilatation of the veins with age.

Most of the emboli originate in the leb veins, since the venous pathways are longer, develop a larger cross-sectional area with age, and usually have more severe and prolonged vasoconstriction. *Harry A. Davis: Studies in thrombo-embolic disease: 1. acute early pulmonary embolism (within forty-eight hours) following surgical operation, trauma, and hemorrhage. Ann. Surg. 137 :356, 1953, as abstracted in Journal-Lancet, Sept. 1953.*

DOCTORS RATED LAST AS BUSINESS SPENDERS

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Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
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The willingness to accept the more common explanation for the cardiac disability, such as arteriosclerotic heart disease and/or coronary insufficiency, not only decreases the diagnostic acumen but limits the therapeutic possibilities for a remediable condition.

Thyrotoxicosis should be suspected in all elderly patients with auricular fibrillation who fail to respond to the accepted form of therapy.

In a combined series of 805 cases of nodular goiter, auricular fibrillation occurred in 14 per cent of the cases. A review of 2,958 cases of auricular fibrillation in the literature revealed the presence of thyroid disease in about 9 per cent. This inefficient type of rhythm is present in 85 per cent of all cases of congestive heart failure associated with hyperthyroidism and is the major factor in the production of congestive heart failure in thyroid disease.

The absence of the classical symptoms of hyperthyroidism is a characteristic feature. The fallacy that an increased basal metabolic rate is an essential diagnostic criterion adds to the pitfalls of an inaccurate diagnosis. The basal metabolic rate is often normal or only slightly elevated. In a series of 22 toxic nodular goiters, the basal metabolic rate varied from a minus 12 to a plus 42 with an average of plus 28. In a group of 70 nodular and 30 diffuse goiters with clinical evidence of thyrotoxicosis, the basal metabolic rate ranged from a minus 5 to a plus 19 in 78 per cent of the cases. In our series the range was from minus 15 to a plus 79 with an average of plus 26.9.

A decreased circulation time, which is affected by anemia, fever, B avitaminosis and congestive heart failure, may be suggestive of hyperthyroidism but is not diagnostic. A therapeutic trial with Lugol's has the disadvantage of a lengthy period of observation and delays the use of radioactive iodine.—*Harold H. Joffe, M.D., Duluth; Minnesota Medicine, 36:145, Feb., 1953, as abstracted in Ohio State Medical Journal, August, 1953.*

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The post of Special Assistant (Health and Medical Affairs) to the Secretary of Health, Education, and Welfare went to a prominent Boston physician, Dr. Chester Scott Keefer, professor of medicine at Boston University School of Medicine. Doctor Keefer received his medical degree from Johns Hopkins University in 1922.

In addition to a long career in teaching, the new Special Assistant is an expert on antibiotics, supervising penicillin and streptomycin distribution for the U. S. and allies in World War II. He was chairman of the National Research Council's committee on chemotherapeutics which advised on civil defense medical stockpiling. Doctor Keefer has been physician-in-chief at Massachusetts Memorial Hospital since 1940. He is a fellow of the American College of Physicians, a member of the American Society of Clinical Investigation and has served on the American Medical Association's Council on Pharmacy and Chemistry.

Under terms of Reorganization Plan No. 1 creating the department, the Special Assistant is charged with reviewing and advising the Secretary on all health and medical programs of the department as well as on health and medical legislation. *The Bulletin of the Sangamon County Medical Society, Sept. 1953.*

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Already 2,800,000 of our working population are over 65, and a noted economist has pointed out that the national economy would lose about 10 billion dollars' worth of goods and services if these workers were to be arbitrarily retired. It thus appears theat we shall have too many aged to support in idleness. To attempt to do so would impose a prohibitive burden of taxes and bring lower living standards and privation for all in the future. There must be a change in our ideas about the usefulness of older workers. Charles E. Dutchess, M.D., A RETIREMENT POLICY. Indust. Med., Aug. 1953.

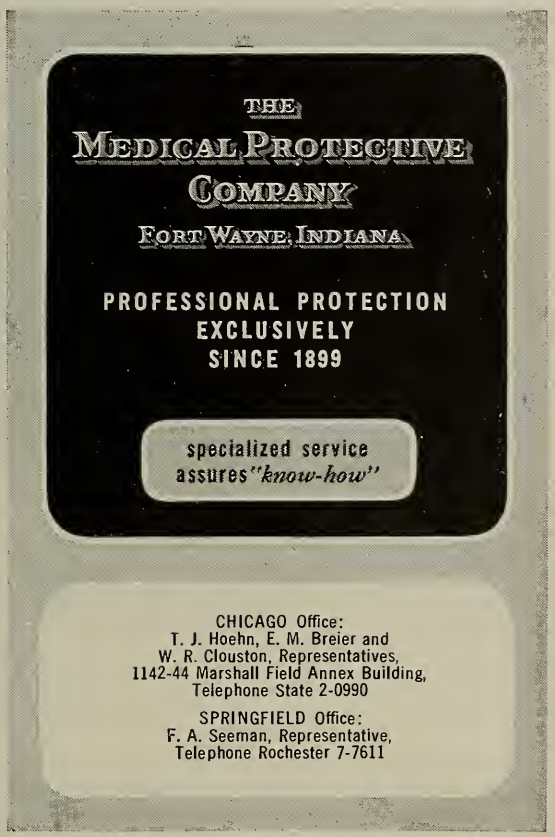
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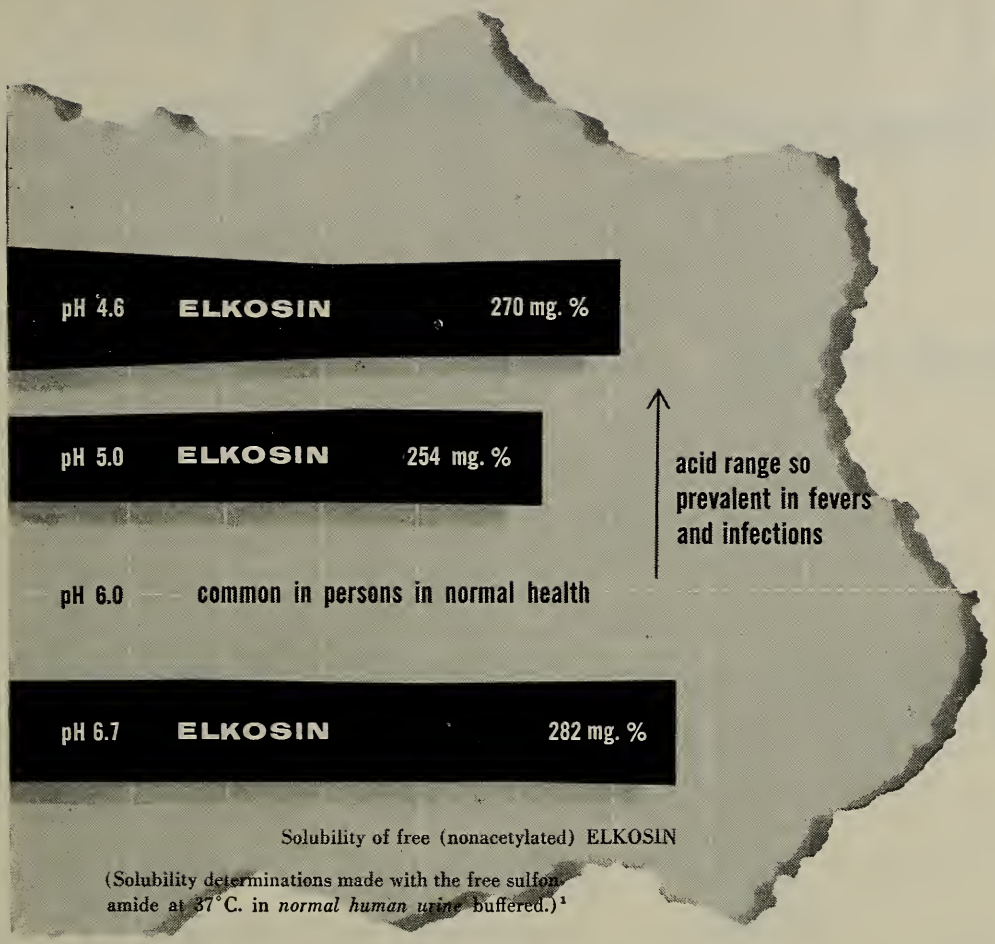
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Dr. Elmer L. Henderson, 68-year-old Louisville surgeon, who championed many fights on behalf of medicine and the profession, passed away peacefully at his home July 30 after a lingering illness. He had undergone several operations, but his condition continued to deteriorate. From a deep coma of a few days duration, he went into a lasting sleep.

Doctor Henderson built for himself an enviable record of achievements on behalf of medicine. The heritage he left among the men of medicine is an everlasting tribute to his memory. His fine competence, his high integrity and his keen sense of humor endeared him to the hearts of everyone—physician and layman alike. That he was well liked is attested to by the fact that he held nearly every high medical office that a doctor could achieve.

He served as presidents of the world's two largest medical organizations -- the AMA and the World Medical Association; he served as chairman of the Board of Trustees of the AMA and also as chairman of its executive committee; he served the armed forces in three wars; he served simultaneously as president of the Southern Medical Association and the Southeastern Surgical Congress; he held every important medical office in his home state, including that of president of the Kentucky State Medical Association and the Jefferson County Medical Society.

His biggest and toughest job was carried out in 1948 when the House of Delegates voted to embark on a national education campaign against the socialization of medicine in the United States. The House set up a Campaign Coordinating Committee, made up of 11 prominent physicians, and Doctor Henderson was made chairman. From December, 1948, until September, 1952, he tackled the job with a stamina that knew no bounds. His leadership in this vigorous and effective campaign against political medicine will never be forgotten! He always carried a "Jack Dempsey punch" for what he thought was right for his patients. *Bulletin, Sangamon County Medical Society, Sept. 1953.*

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There is no registration fee.

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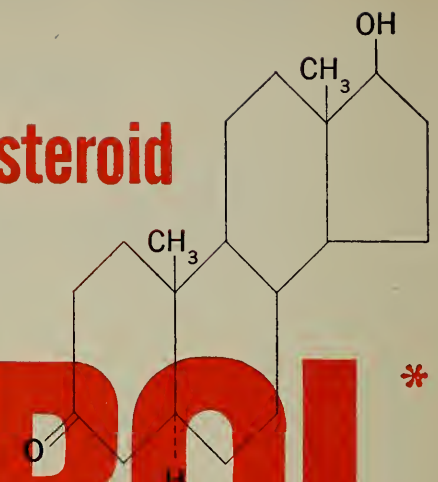
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The ILLINOIS Medical Journal

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Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

Vol. 104, No. 5 November, 1953

Screening for Diabetes

G. Howard Gowen, M.D.*
Springfield

This is a report covering the urine testing project conducted at the 1953 Illinois State Fair, Springfield, Illinois.

The Galatest® was used for the basic screening. Since, with the Galatest, it is sometimes difficult to pass on borderline cases because the color difference is not easily apparent, the Clinitest® was employed as a check on such ill-defined reactions. Effort was made to refer as few unjustified suspects as possible to the practicing physician.

Disposable equipment was used to the utmost because facilities for washing glassware were not easily available. One reason the Galatest was chosen was that it obviated the use of test tubes. Plastic straws were substituted for medicine droppers. The actual tests were made on glossy white shelf paper. The paper was placed on a table top and superimposed on it was a plastic open frame divided into 25 squares (3 in. by 3 in.). The square openings in the frame were numbered from 1 to 25. This automatically provided 25 testing areas on the paper large enough to hold the urine containers. After the paper area in each of the 25 squares had been used, the frame was lifted, the old paper disposed of, and a new sheet substituted.

The Diabetes exhibit and the urine testing station were set up on the balcony of the Illinois Building (the permanent structure for the display of State activities) which contained all exhibits of the Department of Public Health and was designated the Hall of Health. A spot was chosen next to the women's rest room and close to the men's rest room for obvious reasons. Signs were placed in each of the rest rooms urging people to submit specimens, and containers were provided for this purpose. Paper cups were supplied to eliminate the washing of glass vials. There was no apparent resistance to their use.

When a urine specimen was submitted, it was placed in one of the vacant squares. The person was given a card containing the corresponding number, and waited while the test was being made. After the reaction had been interpreted, the number was called, the person holding the number was given the report and the numbered card was turned in. All negative reports were given verbally, but in the case of positives, a form was handed to the person in question.

Women showed far greater interest and were much more cooperative than men. Men exhibit less interest in health matters as a rule, but in this case it was felt that there was an additional factor the urine testing booth was manned exclusively by women. Next year it is planned to have a separate booth for men, operated by men, to try to answer this question.

It was quickly learned that the number of specimens submitted depended on the interest and promotional efforts of the persons running the booth. With very little encouragement, people would submit specimens, but without it they would be passive.

*Deputy Director, Division of Hospitals and Chronic Illness, Illinois Department of Public Health.

Many questions were asked of the booth attendant that were definitely of a professional nature. It is our feeling that a nurse should be present at all times, plus whatever personnel is needed. Also, the nurse should be in uniform. Samples of some of the questions asked are as follows:

Can diabetes be cured?
What causes diabetes?
Is diabetes inherited?
Is diabetes common in young people?
Is hunger for sweets a symptom of diabetes?
Does eating sweets give a positive urine test?
If a slightly positive urine test has occurred, how often should there be a recheck?

These are obviously questions that could neither be intelligently nor satisfyingly answered by a non-professional person.

A total of 1657 specimens from presumably normal persons were submitted over a ten day period. Of these, 247 gave positive reactions. In addition, 16 known diabetics asked to have samples examined because they had never seen the Galatest before. Each person submitting a specimen was screened with the question — *are you a diabetic*, since it was our purpose to find unknown cases. The vast majority of urine samples were submitted by women. Many persons asked for the test because there had been diabetes in the family. Most of those tested were over forty, although there were a few children as part of a family group. The following tabulation shows the number of specimens examined each day, including the known diabetics:

	Date	*Total*	*Positive*
August	14	46	5
	15	47	3
	16	57	10
	17	158	43
	18	194	23
	19	343	79
	20	333	34
	21	155	46
	22	294	19
	23	46	1
		1673	263

Based on the Oxford, Massachusetts experience, a substantial number of cases of frank diabetes and persistent glycosurias without hyperglycemia will be found among the 247 positive reactors without known diabetes, *if they report to their physicians as recommended.* Since we were experimenting to find out if urine testing at the Fair was practicable and if there would be much public interest, no provision was made for follow-up. In the future, this procedure will be instituted particularly to find out if the positive reactors go to their physicians, for final evaluation of the finding.

SUMMARY

1. Urine testing for sugar, using the simple technique described, is practicable for State Fairs, County Fairs, or any assemblage of a convention nature where health exhibits are used.

2. The public is interested in such screening, and with a little promotional effort on the scene, can be motivated to submit specimens.

3. Urine testing enhances markedly the value of a diabetes exhibit.

4. Because many technical questions are asked at the booth, it is important that someone be present who can answer them at a professional level preferably a nurse, and in uniform.

5. Seeing the tests performed is a great interest catcher, because there is a feeling of audience participation, even though by remote control.

DIAGNOSING DIABETES

Sugar found in the urine on screening tests should never be disregarded. The diagnosis of diabetes cannot rest upon this finding alone, but the probability of diabetes is high if a positive test is obtained two to three hours after a meal containing a large amount of carbohydrate, especially if the individual is overweight or if there is a family history of diabetes. *Suggested Medical Procedures And Reporting Methods For Followup. Amer. Diabetes Assn., Inc. 1953.*

Complications of Labor

J. H. Randall, M.D.
Iowa City, Iowa

In the past decade the attitude toward the treatment of many complications of labor has changed. Great improvement has been accomplished in the reduction of maternal and to a lesser extent fetal mortality. Better prenatal care, more competent physicians in the field of Obstetrics, improved technics of anesthesia, greater availability of blood, increased hospital facilities, and the widespread use of antibiotics have all contributed much in making childbearing safer for the mother and her baby.

At the present time cesarean section is a safer operation than it was many years ago. Its indications can be more widely extended without reducing but rather improving results in the treatment of various complications of labor. Many of the difficult and traumatic obstetric operations of the past should be discarded in favor of abdominal delivery. Cesarean section has often been done without a proper indication, and in some cases it has not been done although definitely indicated. Many patients are admitted to the University of Iowa Hospitals after they have had a previous elective cesarean section for contracted pelvis. Most of these contractions are borderline and would permit vaginal delivery if the patient were given an adequate trial of labor. Some patients having vaginal bleeding not due to placenta previa are sectioned but could be delivered vaginally without difficulty. It would seem prudent to extend the indications of cesarean section to many conditions which in the past were treated by vaginal delivery with considerable trauma to mother and baby and decrease the number of poorly indicated sections.

There is no place in modern obstetrics for difficult and traumatic forceps. If conditions for forceps application exist, and if after complete rotation of the head, trials of moderate traction cannot accomplish moderately easy delivery, the operation should be abandoned in favor of cesarean section. A low cervical or extraperitoneal cesarean section done under heavy antibiotic protection is a safer procedure. Many physicians persist in employing difficult forceps, or internal version and extraction, both of which result in considerable trauma hazardous to both mother and baby. In our institution failed forceps treated by internal version and extraction has resulted in an appalling fetal mortality of 60 per cent.[1] This is the experience of other clinics that employ this operation as an alternative procedure to difficult forceps. Patients who experience a traumatic delivery have fewer subsequent pregnancies, either because of infertility or because of fear which compels them to avoid conception. Internal version should never be employed except in rare instances when the second twin presents by the shoulder or in those situations when the cord has prolapsed at full dilatation of the cervix and conditions are still favorable for this procedure.

Every physician when confronted with difficult forceps should consider the possible causes. Failure to recognize and correct an unrotated head, such as an occiput transeverse or occiput posterior, and the lack of complete cervical dilatation are often the cause of failed forceps. Any difficulty due to cephalo-pelvic disproportion should not be treated by brute strength but rather cesarean section. In many instances more time allowed for cervical dilatation or for the occiput to rotate spontaneously will often pay great dividends with gratifying results. Certainly, an unrotated occiput should not be delivered as such unless it can be done with relatively easy traction. In the past few years in our hospital, when difficult delivery was anticipated, a trial of forceps has been done under anesthesia with patient and room prepared for cesarean secton if difficulties arose. One should always expect trouble if the fetal head does not come down into low pelvis when the patient has been given an adequate second stage of labor. It is usually futile for more than one physician to try to deliver a baby when forceps by a previous competent

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person has failed. Many doctors are deeply chagrined to back out of a difficult forceps and employ abdominal delivery but it is usually the better plan of wisdom.

A transverse lie of the baby discovered antepartum should be treated by external version. Any tendency of the fetus to assume this position in a primigravida is suggestive of a contracted pelvis or obstruction of the birth canal by tumor or placenta. A transverse lie of the baby discovered during labor should be treated by cesarean section. If discovered after complete dilatation of the cervix and conditions are favorable, version may be attempted. A neglected transverse presentation, even for the average obstetrician, could probably be more safely handled by abdominal delivery than by decapitation which looks easy but often is associated with rupture of the lower uterine segment.

Twin pregnancy is often a problem in the second and third stages of labor. Obstetric complications of all kinds are more common in twin than single pregnancy. The second stage of labor for the first twin should be governed by the same rules as for the management of the second stage of any single pregnancy. After delivery of the first twin and after severing the cord between clamps, the hand of the obstetrician should be inserted immediately into the uterine cavity. The second sac is ruptured and as soon as the anmiotic fluid has drained away the presentation of the second twin is established. If it presents by a shoulder a version is performed, if by the breech, immediate extraction is done, if by the head, pressure from above will often succeed in pushing the presenting part low in the pelvis so that it can be easily delivered with forceps. Because of the large area of placental attachment and because of uterine atony abnormalities of the third stage must be anticipated.

Until recent years it was felt by most obstetricians that prolapse of the cord should be treated by vaginal delivery. Most clinics today favor abdominal delivery if the fetus is in good enough condition to insure a reasonable chance for a viable baby. Should the cord prolapse in the second stage the baby should be delivered vaginally by whatever method seems expedient for the conditions present.

Breech delivery represents 3 to 5 per cent of all cases and often presents considerable difficulty to the average obstetrician. Attempts should be made to turn the breech into a head presentation during the antepartum course of the patient. External version will halve the incidence but not eliminate breech delivery. Any primigravida with a breech who is to be delivered vaginally should have a careful evaluation of her pelvis by X-ray and manual pelvimetry. It should be pointed out that it takes lesser degrees of pelvic contraction in the breech case to indicate cesarean section than when the head presents. Elderly primigravidas with a breech baby should probably be delivered by cesarean section. The first stage of labor in a breech case is conducted about the same as in a head presentation, except a greater effort is made to preserve the membranes intact, and to follow the patient more carefully with vaginal and rectal examinations. The second stage is managed differently in various clinics but for most physicians it seems best to allow the breech to come down slowly and dilate up the pelvic floor during many contractions. This insures complete dilatation of the cervix. When the presenting part is distending the outlet, the patient can be anesthetized and the breech delivered by fundal pressure. A generous episiotomy should be done to protect the rectal sphincter and to facilitate delivery. Incomplete cervical dilatation and retraction give rise to difficulties in delivering the aftercoming head and the arms which are often extended. Well flexed arms give the physician no difficulty, and the head can usually be delivered easily through a well dilated cervix by manual manipulations (Veit, Smellie, Mauriceau maneuver) unless there is cephalopelvic disproportion. One should be especially careful not to hurry the delivery when the fetus is a premature or footling breech for in these the breech often comes through an undilated cervix. Immediate decomposition of the breech at the beginning of the second stage is to be condemned unless necessary because of poor condition of baby or mother.

Prematurity is seen in 5 to 7 per cent of all deliveries. In a premature labor the fetus should always be protected against infection by giving the patient antibiotic drugs. The mother should be administered no drugs for analgesia and should have no inhalation anesthesia for the birth. Local infiltration or pudendal block anesthesia are excellent for a premature birth

and they can be easily mastered by any physician. The second stage should not be routinely ended with forceps. The fetal head can be delivered easily by Kristeller pressure from above after a generous episiotomy. Trauma associated with delivery, analgesia with depressant drugs, or inhalation anesthesia greatly jeopardize the chances of the baby. The cord should be allowed to quit pulsating before being severed except when the fetus is erythroblastotic.

Prolonged labor (over 30 hours) occurs in 3 to 4 per cent of parturitions. It is usually due to primary uterine inertia, cephalopelvic disproportion or an abnormal presentation. All primigravidas should have X-ray pelvimetry if the pelvis has not been previously carefully evaluated by this method. In prolonged labors the pelvis is often mildly contracted. The bowels and bladder should be kept empty, and nutrition and fluid balance should be maintained by parenteral fluids. Antibiotics should be given to protect the baby from infection. Unless delivery is impending within a short time sleep should be assured by giving 15 mgm. of morphine. The membranes should be ruptured after half dilatation of the cervix unless contraindicated by breech presentation or a high presenting part. This procedure exposes the amniotic cavity to infection but often stimulates labor to a successful conclusion. Pitocin in 5 per cent dextrose has been recently advocated in prolonged labor by some physicians. It should never be used within the first 24 hours of labor and when used in the second 24 hour period it is given slowly starting with ¼ minim and never giving more than ½ minim per half hour. A physician should be in constant attendance during its entire administration so that it can be immediately discontinued if severe or tetanic contractions are produced. It should never be given except in the first stage and then only in primigravidas with primary inertia. At the end of 48 hours of prolonged labor the patient should be carefully evaluated and, if delivery does not seem imminent and progress has been stationary, a low cervical or extraperitoneal section should be done. A physician cannot predict during the first 24 hours that a patient cannot successfully be delivered by the vaginal route, and if labor is terminated within the first day many unnecessary sections would be done. There is not much danger to the fetus from intrauterine infection and anoxia within the first 48 hours but after this period there is considerable hazard often resulting in death in utero. Any prolonged labor which is terminated my an operative procedure before full cervical dilatation or with the head not in low pelvis will be associated with considerable trauma to both mother and baby.

No patient with placenta praevia should ever be allowed to labor unless the degree of placental encroachment upon the cervix is so mild that simple rupture of the membranes controls bleeding. All other cases of previa should be delivered by cesarean section as soon as the baby is viable or when one's hand is forced to end the pregnancy because of severe bleeding. It is an unwise procedure to subject all patients with vaginal bleeding in the last trimester of pregnancy to an immediate section before a definite diagnosis of placenta praevia has been established. This can be done by soft tissue X-ray technics and cystrograms of the bladder, or by vaginal examination in the operating room just prior to the time of the section.

Most patients with abruptio placentae should be delivered vaginally. Labor should be initiated by rupture of the membranes, abdominal binder, and in some cases by pitocin stimulation. Those with concealed hemorrhage will have an inert uterus and should usually be delivered by section. Cesarean section should also be performed in those cases that develop a bleeding tendency due to afibrinogenemia and in those whose baby is greatly embarrassed by the additional disturbance of fetal circulation due to uterine contractions.

Hemorrhage during the latter part of pregnancy has in Iowa become the most common cause of maternal deaths. A proper conduct of the third stage of labor should greatly reduce the number of mortalities from hemorrhage. It is a routine in our hospital to give intravenous ergotrate with delivery of the anterior shoulder. Within one or two contractions of the uterus the placenta separates and can be expressed by pushing on the contracted uterine fundus in the axis of the birth canal. Following delivery of the placenta the physician can devote his attention to the repair of lacerations or episiotomy with little worry from atonic bleeding. Any hemor-

rhage following the third stage which is not readily and completely controlled by uterine massage and oxytocics should lead to a careful inspection of the lower birth canal for lacerations and to palpation of the uterine cavity for retained placental fragments and any rupture of the uterine wall. A placenta which has not separated within twenty minutes after delivery, or any moderate hemorrhage before complete separation are indications for immediate manual removal. In days past the physician was taught not to invade the uterus following delivery except as a last resort, but today under antibiotic protection it is safer to explore the uterus than to procrastinate. Opinions are greatly divided as to the efficacy of a uterine pack for the control of postpartum bleeding but certainly packing more than once is to be condemned. Hysterectomy occasionally will be necessary and should not be postponed until the patient is in an extremely poor condition. There is too much tendency on the part of the medical profession to use blood substitutes to combat hemorrhage and there is too much hesitation to explore the birth canal because of exaggerated statements concerning the danger of such a procedure. Physicians in general underestimate the amount of bleeding during and after the third stage and often fail to recognize deaths due primarily to hemorrhage. Often the causes of death stated on death certificates are heart failure, pulmonary embolism, or shock. Most deaths from hemorrhage are preventable. Above all do not hesitate to call for consultation when faced with uncontrollable hemorrhage during labor.

It will be necessary to interrupt the pregnancy of certain patients who have moderate and severe preeclampisa which fails to respond to the usual regimen of therapy for this complication. In our clinic if the cervix is ripe (partially dilated and effaced) labor is induced by simple rupture of the membranes. If the cervix is unripe as it is in many premature primigravidas, pregnancy is terminated by low cervical section under local anesthesia or nitrous oxide inhalation anesthesia with curare. A parturient with preeclampsia should be carefully watched with respect to blood pressure, pulse, respiratory rate, and urinary output. Intramuscular injections of 50 per cent magnesium sulfate, as advocated by Eastman[2], has been very effective in preventing eclampsia and produces no respiratory depression in the baby. Ten c.c. of a 50 per cent solution of magnesium sulfate are given in each buttock as an initial dose, and the same procedure repeated every six hours using 5 c.c. It is discontinued if the reflexes become markedly slowed or if the respiratory rate falls below 16. If the 24 hour urine output is less than 600 c.c. magnesium sulfate is discontinued after 24 to 36 hours. Morphine is not used because of its effect upon fetal respiration and its tendency to decrease urinary output. Drugs which produce excitement, such as scopolamine and bartital compounds are not used. The second stage of labor should be shortened by forceps if there is any tendency toward prolongation.

Cardiac patients should be under careful management throughout pregnancy and should usually be allowed to go to term. Spontaneous labor is awaited unless there is some definite indication for induction. Analgesics which might excite the patient are contraindicated. Demerol (100 mg.) or morphine (8 mg.) permit adequate rest for the cardiac patient. When the head has reached the pelvic floor, bearing down efforts should be prevented by low forceps. Cardiac patients should not be delivered by cesarean section unless there is some obstetric indication for the operation.

In conclusion it must be emphasized that complications of labor must be treated by those methods which offer the greatest safety to the mother and baby. Many obstetric procedures which were commonly used in the past, such as traumatic forceps and internal version have a greater risk than cesarean section. Bleeding during and after the third stage must be more vigorously treated. There should be no hesitancy to invade the uterus to discover sources of hemorrhage or to remove the adherent placenta manually.

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Preliminary Clinical Report on a New Surface Anesthetic Agent

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Since the introduction of cocaine by Carl Koller in 1884 numerous compounds have been synthesized for use as surface anesthetics. Fifty or sixty drugs are now being manufactured for this purpose; all to a greater or lesser degree have the disadvantage of inadequate anesthesia and of producing sensitivities and irritations.

A new surface anesthetic agent was used in this study at Wesley Memorial Hospital and in the dental clinic of Northwestern University. The drug is para-butoxyphenyl gamma-morpholinopropyl ether hydrochloride (Figure 1).

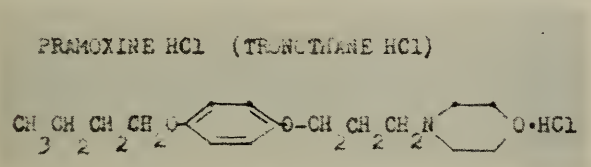


Figure 1

It was synthesized at Abbott Laboratories, and is known as Tronothane. Tronothane is structurally different from all other topical anesthetics now available, thus reducing the likelihood of cross sensitization. It contains neither the para-aminobenzoic acid group, nor the radicals such as diethylamino, dimethylamino, dibutylamino, methyl piperidine, isoquinoline, and esters, amides, and anilides which are frequently associated with toxicity and pharmacologic activity. It contains an ether linkage and morpholino radical, both of which differentiate Tronothane from other anesthetic agents. This unique chemical structure permits the use of Tronothane where sensitization to other anesthetic agents is known or suspected.

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This study was made possible by a grant from Abbott Laboratories.

In a previous study in sensitizing properties of Tronothane by Schmidt, Berryman, McAndrew, and Richards[1], a six week test on 71 volunteer adults has shown that Tronothane has a low sensitization and irritation potential. Cross sensitization did not occur in several cases where there were sensitivities to other topical anesthetic agents. During this test Tronothane Hydrochloride jelly was applied continuously for 23 days. In the subsequent period of challenge patch tests, sensitization reactions, when they did occur, were of a mild to moderate character. The incidence of such reactions was approximately one-fifth that observed in a similar test on the same subjects using cyclomethycaine, another topical anesthetic which is used widely for similar purposes.

In this composite study the drug was given to the various departments of the hospital with instructions as to its use. The departments were Obstetrics and Gynecology, Proctology, Anesthesiology, Urology, and Dental. Four hundred ninety-five patients received treatments. Records were kept for each patient on mimeographed forms and were returned to the anesthesia department for statistical analysis.

The preparations used were a 1% thin jelly, 1% thick jelly, 1% cream and 1% solution. The amount of the drug used varied from an amount necessary to cover a small portion of mucous membrance (as prior to dental injection) to a full ounce in rectal surgery. In no case in this study was a sensitivity observed. These patients complained of slight burning immediately after the application of the drug. In each of the three cases this was a transient sensation disappearing as soon as anesthesia was established.

In obstetrics the heavy jelly was used in 189 patients with episiotomy wounds and lacerations. The preparation was applied directly to the wound whenever discomfort occurred, usually every 4 to 6 hours. Two collaborative studies by Charles H. Birnberg of Brooklyn, N. Y.[2]

CHART 1
USE OF TRONOTHANE IN OBSTETRICS*

Number of cases	189
Excellent results	101
Good results	56
Percent — Excellent and Good Results	83

*Including two series from Charles H. Birnberg, M.D., Brooklyn, New York, and H. E. Schmitz, M.D., Chicago, Illinois.

CHART 2
USE OF TRONOTHANE IN PROCTOLOGY

Number of cases	60
Excellent results	38
Good results	18
Percent — Excellent and Good Results	93

CHART 3
USE OF TRONOTHANE IN GENITO-URINARY CASES

Number of cases	132
Excellent results	110
Good results	16
Percent — Excellent and Good Results	95%

CHART 4
USE OF TRONOTHANE IN DENTAL PROCEDURES

Number of cases	42
Excellent results	30
Good results	6
Percent — Excellent and Good Results	81

CHART 5
USE OF TRONOTHANE IN ANESTHESIA

Endotracheal tubes:	
Number of cases	47
Excellent results	38
Good results	6
Percent — Excellent and Good Results	91
Levine tubes:	
Number of cases	24
Excellent results	22
Good results	—
Percent — Excellent and Good Results	91

CHART 6
SUMMARY OF EFFECTIVENESS OF TRONOTHANE IN VARIOUS CLINICAL FIELDS

Type of Case	Number of Cases	Excellent Results	Good Results	Percent Excellent and Good
Proctology	60	38	18	93
Cenito-urinary	132	110	16	95
Obstetrics*	189	101	56	83
Dental	42	30	6	81
Anesthesia:				
Endotracheal tubes	48	38	6	91
Levine tubes	24	22	—	91

*Including two series from Charles H. Birnberg, M.D., Brooklyn, New York, and H. E. Schmitz, M.D., Chicago, Illinois.

and H. E. Schmitz[3] of Chicago have been included in Chart 1. One hundred fifty-seven (83%) patients had good to excellent relief of burning and pain.

In proctology the heavy jelly was applied immediately postoperatively to patients with hemorrhoidectomies, repair of fissure in ano and anal ulcers (Chart 2). One ounce of jelly was applied directly from the tube to the operative site, following which, the wound was covered with a dressing. On the first, second, and third postoperative days a 1% solution was sprayed from an atomizer directly onto the incision. Additional solution was sprayed as needed during the remainder of the hospital stay and at home, the patient being his own administrator throughout, using the spray when he felt he needed it. The customary postoperative discomfort that accompanies rectal operative procedures was completely absent in 63% of the patients, and markedly reduced in another 30%, making a total of 93% good to excellent results. In comparing the postoperative pains of those patients who had previous rectal operations, the comment was made that Tronothane "gave more satisfactory relief from pain than any other drug used previously."

In the Genito-Urinary Department the drug was instilled into the urethra of 132 patients by means of a urethral tip attached to the tube of Tronothane jelly. The light jelly was used because its fluid nature permitted the use of the cystoscope with no blurring of the light or smearing of the lenses. Approximately ¼ ounce of the drug was instilled 2 to 3 minutes before the introduction of the cystoscope or the sounds. There were no reactions or signs of sensitivity in any of the cases other than a transitory burning sensation which occurred in the 3 cases mentioned. This disappeared before instrumentation was attempted. Ninety-five per cent of the genito-urinary cases studied had excellent to good results.

The dental department used the heavy jelly in 41 patients, all children, who required local

or nerve block injections; also in tooth cavities which were painful or sensitive to various stimuli (Chart 4). The gum at the site of injection was first dried and the jelly was applied with the finger or a piece of gauze and held in contact with the mucous membrane for one minute. After this application the injection in 30 cases (71%) was a painless procedure; in six cases (14%) only slight sensation of discomfort occurred. Sensitivity to heat and cold was reduced markedly by application of the jelly to the cavities.

Chart 5 summarizes the use of Tronothane in anesthesia. As a thin coating on endotracheal or Levine tubs(the 1% cream was found preferable to the 1% jelly, because of its inherent ability to remain moist for long periods of time. In cases requiring laryngeal intubation, a spray of the 1% solution of Tronothane was utilized. This procedure was well tolerated without evidence of bitter taste or sensitivity. General anesthesia was then instituted and intubation of the larynx effected without "bucking" or other evidence of reflex responses characterizing an un-anesthetized tracheal mucous membrane. Further studies to confirm this impression are under way of laryngeal intubation of conscious patients.

A composite picture of the effectiveness of Tronothane in various clinical fields is presented in Chart 6.

Further studies are planned to determine the effect of the drug as an ophthalmic topical agent.

SUMMARY

A preliminary report on a new surface anesthetic agent is presented. The chemical and pharmacological nature of the drug would lead one to surmise that it may cause minimal primary sensitivity or cross sensitivity. The preliminary clinical trial supports such a contention; Tronothane appears to have excellent surface anesthetic properties with minimal sensitivity.

We wish to express our appreciation to Vincent J. O'Conor, M.D., Department of Genito-urinary Diseases; Durand Smith, M.D. and Francis D. Wolfe, M.D.. Department of Proctology; Edward M. Dorr, M.D., Department of Obstetrics and Gynecology; and George W. Teuscher, D.D.S., Department of Dentistry, all of the Wesley Memorial Hospital, Chicago, for their cooperation in compilation of this data.

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DIABETES DETECTING

All individuals with positive tests for sugar in the urine should be considered as diabetic until proved otherwise. Such cases should be studied and observed for a long period of time. Blood sugar determinations two hours after a specific carbohydrate meal will usually indicate the presence or absence of diabetes. In all doubtful or borderline cases a standard glucose tolerance test is recommended. Those individuals who show glycosuria on screening examinations, and whose subsequent blood sugar tests, either postprandial blood sugars or glucose tolerance tests, are within the normal range, should be observed at least annually for the possible development of diabetes in the future. This is especially true of individuals who are overweight, over 40 years of age, or have a history of diabetes in the family. Such simple direct analysis and observation will undoubtedly lead to a diagnosis of diabetes in many mild cases and, consequently, to the early institution of proper care which may possibly add many years of life and prevent a number of the complications of the disease. *Suggested Medical Procedures And Reporting Methods For Followup. Amer. Diabetes Assn., Inc., 1953.*

The Diagnosis of Occult Ectopic Pregnancy

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Several preventable maternal deaths from ruptured ectopic pregnancy occur each year in every state in our country. During the decade 1931-1940 the proportion of total maternal deaths resulting from ectopic gestation was about 8 percent. Although this figure is now believed to be down to about 3 percent, it should be brought down much nearer to zero. This unnecessary loss of life results from (1) failure of the patient and her family to seek medical care, from (2) their refusal to follow their physician's advice, and from (3) an incorrect diagnosis made by the physician. The making of the incorrect diagnosis results from the physician's misinterpretation of his findings on pelvic examination, or, all too frequently, from failure of the physician to perform a vaginal or rectal examination.

In reviewing several of the cases in which women having ruptured ectopic pregnancy were brought to the Emergency Department of the Detroit Receiving Hospital in an irreversibly moribund condition, we found that a physician had seen a few of them in their homes, but that he had believed them to be having a threatened miscarriage. In view of the physicians' assumption that the pregnancy in these cases was intrauterine they had not done a pelvic or rectal examination lest they handle an already irritable uterus and thereby possibly increase the chances of miscarriage. Had the women presented the classic picture of shock, syncope, distended and tender abdomen, the physicians undoubtedly would not have missed the diagnosis. But the symptoms and signs in these patients were mild, and the ectopic pregnancies were not clinically apparent. We believe, therefore, that a detailed consideration of the differential diagnosis of ectopic pregnancy in the non-obvious, or *occult* type of case, is timely.

In our experience the first step in the differential diagnosis of suspected and non-obvious cases of ectopic pregnancy is to establish, if possible, if the patient *is or is not pregnant.* The second step is to try to determine, provided the patient *is* pregnant, *if the pregnancy is intrauterine or ectopic in location.* These two steps may be extremely difficult to accomplish, especially if the pregnancy is unruptured, or if the fetus is dead and the conceptus is regressing. When there has been death of the fetus and beginning regression of the conceptus in *intrauterine* pregnancy, abortion may shortly occur, or the pregnancy may be retained and the status known as "missed abortion" may thus be established. In *ectopic* gestation, when the conceptus regresses, there may be a gradual diminution of symptoms since rupture of the ovum through the wall of its containing maternal organ under these circumstances may not occur. This is true regardless of whether the containing organ is the uterine cornu, the Fallopian tube, the broad ligament, or the ovary, or any combination of these structures.

The biologic pregnancy test, whether one employs the classic Ascheim-Zondek method, or the currently popular "rapid frog test", is of real help in some cases in accomplishing the first step, particularly when the clinical data and findings on physical examination are equivocal and the pregnant tube has not yet ruptured. If the conceptus is not surviving in a healthy manner, the quantity of chorionic gonadotropin excreted in the patient's urine may be so low as to give a negative or only a very weak positive result, and it is imperative that the laboratory personnel report all grades of weak positivity of the test, since a false negative report can endanger the patient's life if she is unwittingly

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discharged from immediate surveillance. As long as any appreciable quantity of trophoblastic tissue remains alive in the patient she will excrete some chorionic gonadotropin in her urine, and this may or may not be an amount sufficient to give a positive test. The reliability of any biologic pregnancy test varies from one laboratory to another, but most can give better than 50-75 percent accuracy in cases of unruptured ectopic pregnancy if all due precautions are taken to insure against errors.

Once the decision of the first step has been reached, namely, that the patient *is* pregnant, the question to be answered in the second step must be explored. The question of whether the pregnancy is intra- or extra-uterine is of crucial importance. This importance increases the further along in pregnancy a given case happens to be, since the further an ectopic pregnancy advances the greater is the risk to the patient's life. This fact is best exemplified by cases of advanced abdominal pregnancy.

If the patient is pregnant the conceptus may be contained in the uterus, and, if so, careful pelvic examination may reveal that the uterus is enlarged, soft, and somewhat "cystic" in feel. Many times a patient may be unable to relax her abdominal musculature or may be so uncooperative or obese that actual bimanual palpation of the uterus cannot be achieved. Under these circumstances, a gentle and thorough pelvic examination performed on the anesthetized patient is mandatory, and it must be remembered that the relaxation of the abdominal musculature thus induced requires the exercise of great gentleness in handling the pregnant uterus lest some trauma unwittingly be done to its contained conceptus.

Soft tissue technique x-ray studies of the lower abdomen and pelvis, with or without pneumoperitoneum, are frequently of great value in determining the location of the pregnancy. An oblique view, taken through the patient's pelvis while she lies in a position half way between flat-on-her-back and straight-up-on-her-side can be of particular value since the outline of the uterus may be framed in the sacro-sciatic notch which is thus juxtaposed to the x-ray table. The uterus may or may not show some enlargement, and if the pregnancy is of 16 or more weeks in duration there may be enough calcium in the fetal skeleton to permit its showing faintly on a film so exposed. Such x-rays of early pregnancies are of no value unless a definite soft-tissue technique is employed, and this is accomplished by the simple device of reducing the kilovolts to about 70 percent of the regular values used on a given patient when taking a routine film of the lumbar spine or sacrum.

Insofar as diagnosing rupture of an *ectopic* pregnancy is concerned, culdocentesis has been of very great value to us and has given us the correct diagnosis in practically all of the manifest cases and in about 90 percent of the occult ones.

If, in spite of (1) pregnancy tests, (2) pelvic examination under anesthesia, (3) soft-tissue x-rays, and (4) culdocentesis, we are still unable to learn whether the pregnancy is intra- or extra-uterine, we perform an exploratory laparotomy in order to determine this point. In 1952 we had to perform two laparotomies under such special circumstances, and we found a ruptured corpus luteum hematoma of the ovary in one patient and a normal intrauterine pregnancy in the other. Since the Gynecology Service at the Detroit Receiving Hospital is the teaching service of Wayne University College of Medicine, we naturally have a few maxims we teach and follow. One of the best of these, and one which has served us well and had undoubtedly saved the lives of quite a few women, is the following: "When there is a *reasonable* suspicion of the presence of ectopic pregnancy, exploratory laparotomy is mandatory". The value of this rule to us is attested by the fact that in a recent series of 136 consecutive cases of tubal pregnancy published from the Gynecology Service at the Detroit Receiving Hospital[1] there was only one fatality ascribable to ectopic pregnancy itself, and this patient was not seen by us but was treated on the Surgery Service. She was thought to have a malignancy of the sigmoid colon, which impression was substantiated by x-ray studies, but laparotomy disclosed, instead, that an old ectopic pregnancy had perforated the sigmoid. Although a colostomy was performed the patient died of generalized peritonitis. We have since had over 100 additional cases of ectopic pregnancy with no deaths.

The third and fourth year medical students

on duty with the gynecology resident in the Emergency Room of our hospital unfailingly make the correct clinical diagnosis on the classic acute, or *manifest, cases of ruptured ectopic pregnancy.* Everyone is familiar with the characteristic triad of symptoms — lower abdominal pain, irregular vaginal bleeding, and syncope. In addition, in our published series[1], nausea and vomiting had occurred in 9 percent, generalized weakness in 4 percent, and rectal pain and anorexia had each occurred in 2 percent of the cases.

The classic physical findings, in the obvious case, are lower abdominal tenderness, and, on pelvic examination, tenderness in the cul-de-sac region and tenderness on passive motion of the cervix. A pelvic mass was palpated in 36 percent of our cases, while shock and/or a systolic blood pressure of less than 90 mm. of mercury were found in 33 percent[1]. Only about two thirds of these women, as the result of abdominal palpation, percussion and auscultation, gave evidence leading to the belief that there was free blood in the peritoneal cavity, and yet needle aspiration of the cul-de-sac through the posterior vaginal vault yielded bloody fluid in 95.3 percent of the series, which certainly epitomizes the real value of culdocentesis in our experience.

We operate upon 60 to 70 patients having ectopic pregnancy each year, and about two thirds of them are classic, or *manifest* cases of ruptured ectopic pregnancy, and are easily diagnosed as such. In them the Fallopian tube has ruptured at the pregnancy site and there has been a sufficiently large and abrupt disruption of the tube wall to cause considerable sharp, local pain and the sudden loss of a large amount of blood into the peritoneal cavity, with the expected resultant syncope and shock, and the rapid development of generalized lower abdominal pain as the blood fills the pelvis and irritates its parietal peritoneum.

The other one third of the cases which we regularly see — the *occult* cases — are difficult to diagnose because the symptoms and physical findings are mild and indefinite. In them the rupturing of the tube is a slow and gradual process, or has not yet occurred, and the bleeding into the abdomen is only slight in amount, or, again, has not occurred. There is no sudden and acute lower abdominal episode, therefore, nor is there usually any pain of more than slight and transitory nature. In a few cases there is gradual and almost asymptomatic abortion of the conceptus from the fimbriated end of the tube, or, the pregnancy in the tube begins to regress and resorb before more than a slight degree of rupture has occurred.

The clinical picture of the *occult* cases of ectopic pregnancy, in our experience, is one in which the symptoms are vague and slight. About two thirds of these patients have lower abdominal pain as their chief complaint, and it is unilateral in about half the cases. Approximately one third of these women give a history of having missed one or two menses and then of having had some slight, irregular spotty vaginal bleeding. None of them have experienced syncope, nausea and vomiting, weakness, anorexia nor rectal pain. The findings on physical examination are likewise not very remarkable in that they are not in shock, their blood pressure and pulse readings are normal, and they may not be having any pain at the time of examination. The abdomen may be normal to percussion, auscultation and palpation, and on pelvic examination the findings may be equivocal or normal.

In some of these occult cases, however, we have found mild deep tenderness in one lower quadrant over the adnexal area, there may be slight tenderness on manipulation of the cervix, and slight tenderness of the peritoneum in the cul-de-sac. In a few cases adnexal masses are made out, especially if pelvic examination under anesthesia is wisely resorted to. We have not felt so much at a loss in correctly diagnosing these occult cases since, in 1948, we began to do routine needle aspiration of the cul-de-sac through the posterior vaginal vault in all suspected cases of ectopic pregnancy.

In the series of 136 patients having tubal pregnancy recently published from our service[1], culdocentesis was performed in 129 cases. In 123 instances the intraperitoneal fluid so aspirated was grossly bloody, the other 6 cases yielding only a very small amount of clear or cloudy peritoneal fluid. In 5 of these 6 cases of "negative tap" the tubal pregnancy was still unruptured, as determined at laparotomy. Laparotomy was performed in these 5 patients despite a negative culdocentesis test on the basis of (1) the history of a missed period, with or without

subsequent spotty vaginal bleeding, (2) because of a positive pregnancy test, and/or (3) because of the palpation of an adnexal mass, all of which made us suspicious of ectopic pregnancy. A *reasonable suspicion* of the presence of ectopic pregnancy existed in our minds in these 6 patients, despite the negative cul-de-sac "taps", and so laparotomy was routinely performed. The biologic pregnancy test is of greatest value in those suspect cases in which the cul-de-sac aspiration test is negative, i.e. when there has as yet been no bleeding from the ectopic pregnancy site. It must be reiterated, however, that a negative biologic pregnancy test does *not* rule out ectopic pregnancy.

In 1952 we performed exploratory laparotomy on 64 women because of our relatively certain or only suspicious impression that they had ectopic pregnancy[2]. In 62 of these cases, or 97 percent, ectopic pregnancy was found and was successfully treated. In one case there had been rupture of a hemorrhagic corpus luteum of the ovary while in the other, a very obsese woman, normal intrauterine pregnancy was found. In all of these 64 patients we had obtained non-clotting, bloody fluid upon aspiration of the cul-de-sac, but only 63 of these women actually had free blood in the abdomen. The woman who had a normal intrauterine pregnancy had no hemoperitoneum, and so we misinterpreted a bloody aspiration, which, in retrospect, must have consisted of whole blood aspirated from a vein in the gravid uterine wall itself, since the uterus was in retroposition. This blood probably was diluted by some peritoneal fluid sucked in as the needle tip traversed the cul-de-sac, which prevented it from clotting normally.

During 1952 we missed making the diagnosis of ectopic pregnancy in 2 instances, but one of these women signed out of the hospital before our work-up was complete and had a laparotomy at another hospital after her tube ruptured at home. The other case, whose pregnancy test was negative and culdocentesis unsatisfactory, returned at the first real onset of pain, as instructed, and we successfully performed laparotomy on a very early tubal pregnancy. In these cases of missed diagnosis we had been unable to perform a satisfactory culdocentesis, because of the presence of adherent viscera obliterating the cul-de-sac. Since the organs were adherent we were unable to aspirate either blood or peritoneal fluid.

Culdocentesis, therefore, has been the single most valuable diagnostic test, in our hands, and its accuracy has been 97 percent. In about 90 percent of our cases, when positive, it was the single confirmatory test which clinched the diagnosis, and it was immediately followed by laparotomy. We have considered not only the fact that the blood so obtained came from the cul-de-sac, but that (1) it did not coagulate on standing, and that (2) there usually were present a few minute, as yet incompletely lysed, old blood clots, both of which findings are diagnostic of hemorrhage into the peritoneal cavity. As has been stated, the *apparent hemoperitoneum* demonstrated by the test was confirmed at laparotomy, in 1952, exactly according to our culdocentesis findings with the exception of the one case of intrauterine pregnancy in which accidental uterine wall vena puncture must have been performed. The accurate use of the culdocentesis test includes the discarding of the occasional test "tapping" from the posterior vaginal vault in which one obtains fresh, whole blood which rapidly clots, because in such an instance one must assume that actual venapuncture accidentially has been accomplished. At such a time we wait about 5 to 10 minutes and then tap the cul-de-sac at another point. In performing culdocentesis, therefore, one must beware of inadvertently tapping a completely retroposed pregnant uterus, adherent sigmoid colon, or prolapsed and/or adherent adnexae or other viscera. All cases in which fresh whole blood which clots is aspirated must be carefully considered as to possible source, and judiciously discarded and ignored when such a move is indicated.

The biologic pregnancy test is never necessary in the manifest cases, and needs to be performed only in those occult cases in which there is such a vague basis for suspicion of ectopic pregnancy as not to prompt us to perform culdocentesis. Or, when culdocentesis gives negative results and the patient is in good condition, and yet one is still somewhat suspicious of the presence of ectopic pregnancy, the biologic test can be of help.

* * * * * * * *

Williams made an important contribution to the knowledge of ectopic pregnancy when he

published, in 1944, his excellent paper analyzing 101 fatalities from ectopic pregnancy in the Philadelphia area[3]. In 44 of these cases the correct diagnosis was made before operation, but they had gone so overlong before seeking or receiving medical care that they did not survive. In 21 patients the diagnosis was not accurately determined until operation, and 16 of these were occult cases. Diagnosis was not made until autopsy in the remaining 36 women, 16 of whom had typical or suggestive histories of ectopic pregnancy, while the other 20 were of the non-typical variety. Thus 36 of the 101 fatal cases Williams presented were of the occult type.

In Williams' series[3] an incorrect diagnosis was made in 35 cases. In 11 patients the mistaken diagnosis of pelvic inflammatory disease was made, which is not surprising in view of the fact that from one third to one half of all Fallopian tubes removed because of tubal pregnancy show pathologic evidence of old salpingitis. 9 cases were misdiagnosed as having threatened or incomplete abortion, which is an easy pitfall into which the unwary physician can stumble. In 3 cases the diagnosis of myoma of the uterus was made, but the mass apparently was that of an ectopic pregnancy instead. Two cases were misdiagnosed ovarian cyst, and here again the true nature of the adnexal mass was not appreciated. Two women, apparently because of nausea, vomiting, and abdominal pain, were incorrectly diagnosed as cases of intestinal obstruction, and the following mistaken diagnoses were made on 1 case each: retroposition of uterus, uterine perforation by contraceptive stem pessary, benign uterine bleeding, and anemia.

Falls has presented very clearly the difficulties in diagnosis of certain types of ectopic pregnancy[4]. He makes particular reference to the variations in the clinical picture according to what portion of the Fallopian tube contained the pregnancy. He reiterated that pregnancies in the interstitial portion of the tube are apt to progress longer before the onset of definite symptoms than when the ovum is situated in the middle or distal third of the tube. Also, when the pregnancy is just 1 to 2 centimeters lateral to the uterine cornu, this smallest portion of the tube may rupture relatively early and give marked symptoms of intraperitoneal hemorrhage sometimes even before a mensis is missed[4].

A recent valuable paper by Johnson[5] presents an analysis of 245 cases of ruptured ectopic pregnancy. He divided them into two groups, the "acute manifest cases with signs of internal hemorrhage", which comprised 64 percent of the series, and "obscure latent cases in which the products of conception and hemorrhage are walled off", which made up the remaining 36 percent of his cases. In the manifest group, in his series, the correct diagnosis was made preoperatively in 94.6 percent, while this was accomplished in only 76 percent in the obscure, or "occult" group. In the other 21 cases in the occult group the diagnosis was not clear but exploratory laparotomy was done on the basis of the suspicions of an "ectopic conscious" staff. Here again we see the difficulty of diagnosis offered by the occult group of cases.

* * * * * * * *

The most common erroneous diagnosis of ectopic pregnancy, in our experience, has been *pelvic inflammatory disease.* The differential diagnosis between this condition and occult ectopic pregnancy would seem, at first consideration, to be a simple procedure, but such is not the case. A detailed consideration of the differential diagnosis (Table 1) reveals that about one half of the ectopic pregnancy patients have been sterile for from 3 to 7 years, while a history of complete primary sterility, or of secondary sterility for several years, is slightly more characteristic of the pelvic inflammatory disease cases, but any real differentiation attempted on this point would be unreliable. The recent menstrual history in the cases of ectopic pregnancy is that of missing a menstrual period and the later onset of slight spotty vaginal bleeding, while in the pelvic inflammatory disease group there will not be a missed period but rather polymenorrhoea or menorrhagia, with occasional spotty bleeding before or after the prolonged mensis. Unilateral lower quadrant abdominal pain is present in half the ectopic pregnancy cases, but pain in pelvic inflammatory disease, if present, is usually bilateral. In the other half of the ectopic pregnancy cases the pain is generalized throughout the entire lower half of the abdomen, while in the pelvic inflammatory disease cases the pain is usually limited to the adnexal areas on each side unless there is obvious pelvic peritonitis.

TABLE 1

THE DIFFERENTIAL DIAGNOSIS OF OCCULT ECTOPIC PREGNANCY AND PELVIC INFLAMMATORY DISEASE

	OCCULT ECTOPIC PREGNANCY	PELVIC INFLAMMATORY DISEASE
I. *Reproductive History*		
a. Former pelvic inflammatory disease	In ½ of the cases	In all of the cases
b. Time interval between last pregnancy and present one, or period of sterility	Usually a period of secondary sterility for from 3 to 10 yrs.	Frequently no previous pregnancy, or none for several years.
II. *Recent Menstrual History*		
a. One menstrual period missed, or slight vaginal bleeding when 2-3 weeks overdue	Usually the case	Usually no missed mensis but there may have been menorrhagia, polymenorrhoea and irregular spotty vaginal bleeding.
III. *History of Pain*		
a. Unilateral lower quadrant abdominal pain, usually severe and cramping in nature	Present in about half of the cases	Present in only a few of the cases, but rarely cramping in nature.
b. Generalized lower abdominal pain, usually constant and of moderate degree	Usually not present	The pain is usually bilateral and limited to the adnexal regions, being generalized only if there is severe inflammation and pelvic peritonitis.
IV. *Physical Findings — General*		
a. Patient febrile and ill.	No	Yes, if an acute case, but not so if inflammation is relatively quiescent.
b. Leucocytosis	Usually none	There may be some unless case is quiescent.
V. *Physical Findings — Abdomen*		
a. Abdomen negative except for deep tenderness over the adnexae in the lower quadrant *on one side*	Usual	Unusual, but may be the case
b. Same, except there is *bilateral* lower quadrant tenderness over the adnexal regions	Rare	Usual
VI. *Physical Findings — Pelvic Examination*		
a. Bleeding from external os of cervix	Slight or none	Usually none
b. Slight enlargement and softening of the uterus	May be present	Not present
c. Adnexal (tubal) mass present on one side	Usually present	Masses nearly always bilateral, prolapsed and adherent to the pelvic floor.
d. Peritoneal tenderness in the cul-de-sac region	Present only if there has been bleeding into the abdomen	Tenderness of the adnexal masses themselves, and not primarily in the cul-de-sac.
e. Needle aspiration of cul-de-sac through posterior	Positive bloody tap usually obtained (in about 90 per cent of cases)	Blood rarely obtained, and then only by accidental venapuncture.

With regard to physical findings (Table 1), if the patient is febrile and ill, and has an appreciable leucocytosis, then she probably has pelvic inflammatory disease rather than ectopic pregnancy. Palpation of the abdomen in a case of ruptured tubal pregnancy may show deep tenderness over the adnexae in a lower quadrant on one side, whereas there would usually be tenderness over the adnexae on both sides in women having pelvic inflammatory disease. This point, however, also may be equivocal and quite undependable. On plevic examination, if there is any active bleeding from the cervix the chances are generally in favor of ectopic pregnancy over pelvic inflammatory disease. If the uterus is slightly but symmetrically enlarged and a little softer than normal, then ectopic pregnancy is more likely than pelvic inflammation. If an adnexal mass is palpated only on one side, instead of masses on both sides of the pelvis, then ectopic pregnancy is the more likely diagnosis although this is not a wholly dependable finding. In pelvic inflammatory disease the adnexal masses are nearly always prolapsed and adherent to the *floor* of the pelvic fornix on each side, whereas tubal pregnancies are generally higher up in the pelvis, frequently being at about the level of the uterine fundus. If there is peritoneal tenderness centered in the cul-de-sac region, which is usually the case when there has been some bleeding into the peritoneal cavity, then the case is probably one of ectopic pregnancy, whereas when the tenderness is chiefly intrinsic in the adnexal masses on each side of the pelvis the patient is most apt to have inflammatory disease. Finally, needle aspiration of the cul-de-sac has proven of very great value in the differential diagnosis of these cases, since better than 95 percent of all cases of ectopic pregnancy, in our experience, sooner or later give "bloody taps", and the only time blood is obtained on culdocentesis in cases of pelvic inflammatory disease is when an accidental venapuncture occurs.

The next most common incorrect diagnosis of ectopic pregnancy is *threatened or incomplete abortion.* The differential diagnosis here is not quite so difficult as in the case of pelvic inflammatory disease (Table 2). With regard to the reproductive story there may be a history of pelvic inflammatory disease and previous sterility in over half the ectopic pregnancy cases, while such is rare when there is threatened abortion. Furthermore, there has been previous tubal pregnancy in about 10 percent of these cases, while about half of the threatened abortion patients have had previous abortion and have never had tubal pregnancy. As far as the menstrual history is concerned, the patient having tubal pregnancy usually gives a history of having missed one menstrual period, and of slight spotty, vaginal bleeding, *without midline uterine cramps,* when 2 to 3 weeks overdue. The case of threatened abortion, on the other hand, usually gives a history of having missed 2 menstrual periods, with the onset of some vaginal bleeding, and *with associated midline uterine cramps,* when about 6 to 10 weeks overdue, on the average.

With regard to abdominal pain, the woman having ectopic pregnancy usually has *unilateral,* lower quadrant pain, which may be cramp-like and localized in the adnexal region, or she has fairly constant and generalized lower abdominal pain (when the pelvis is full of blood). This is not the case in threatened abortion, because the uterine contractions cause the pain to be diffusely present in the general *lower midline region of the pelvis.* Furthermore, syncope is rarely present in cases of threatened abortion.

The physical findings vary according to whether the case in question is a manifest or acute, type of ruptured ectopic pregnancy, an occult or non-acute type, or only a case of threatened abortion (Table 2). If the patient has had an appreciable hemorrhage, as in manifest rupture of a tubal pregnancy, she will usually be apprehensive and have a rapid and weak pulse, and will frequently have cold and moist extremities, shock, and a low blood pressure. Such findings are only rarely found in cases of occult ectopic pregnancy and in threatened abortion. Abdominal examination reveals some distension and some moderate and diffuse tenderness, and may give evidence of contained free fluid, or a "doughy" feel, in the usual case of manifest ruptured ectopic pregnancy. In the average occult case, however, the only finding may be some deep tenderness over the adnexae in one lower quadrant. When there is threatened miscarriage the abdomen is generally negative except for the presence of an enlarged uterus usually palpable in the lower midline. On pelvic examination the case of threatened abortion may have consid-

TABLE 2
THE DIFFERENTIAL DIAGNOSIS OF RUPTURED AND UNRUPTURED ECTOPIC PREGNANCY AND THREATENED OR INCOMPLETE MISCARRIAGE

	RUPTURED OR ABORTING TUBAL PREGNANCY	THREATENED, INEVITABLE OR INCOMPLETE ABORTION
I. *Reproduction History*		
a. Former puerperal infection	In about 1/6 of the cases	No history of it
b. Former non-puerperal salpingitis	In ½ of the cases	No history of it
c. Time interval between last pregnancy and present one, or period of sterility	¼ to ½ of cases sterile for preceding 3-7 years	Rarely history of sterility. May be first pregnancy; time interval otherwise normal
d. Number of previous pregnancies	1st or 2nd pregnancy in ½ of cases	No specific relationship
e. Repeated occurrence	Previous or subsequent tubal pregnancy in 8-10% of cases	History of previous abortion in about half of the cases
II. *Recent Menstrual History*		
a. One menstrual period missed, or slight vaginal bleeding when 2-3 weeks overdue	*Usually the case*	Rarely the case
b. Two or more menstrual periods missed, or slight vaginal bleeding when 6-10 weeks overdue	Rarely the case	*Usually the case*
c. Slight, "spotty", irregular vaginal bleeding, *without* uterine (lower midline abdominal) cramps	*Frequently the case*	Rarely the case
III. *History of Pain*		
a. *Unilateral lower quadrant abdominal* pain, usually severe and cramping in nature	Present in half the cases	Rarely present
b. *Generalized lower abdominal* pain, usually constant and of moderate degree	Present in half the cases, particularly when abdomen is filled with blood	Rarely present
c. *Lower midline abdominal* pain, *intermittent* in type, simulating menstrual *"cramps,"* or labor pains	Rarely present	Usually the case

	Acute Type	Non-Acute or Occult Type	
IV. *Physical Findings — General*			
a. Patient very apprehensive	Usually	Occasionally	Occasionally
b. Pulse rapid and weak	Usually	Rarely	Rarely
c. Extremities moist and cold	Frequently	Rarely	Rarely
d. Blood pressure low or at shock levels	Frequently	Rarely	Rarely

(Continued on next page)

TABLE 2 (*Continued*)

V. *Physical Findings — Abdomen*			
a. Abdomen negative, except for slight, deep tenderness over the adnexae on one side	Occasionally	*Usually*	Rarely
b. Abdomen somewhat distended, diffusely and slightly tender, and may have sort of "doughy" feel	Frequently	Occasionally	Rarely
c. Abdomen negative, except for slight sensitivity of slightly enlarged uterus, which may be palpable on deep pressure just above symphysis pubes	Rarely	Rarely	Usually
VI. *Physical Findings — Pelvic* (Examination under anesthesia may be necessary)			
a. Bleeding from external os of cervix	Slight or none	Slight or none	Slight to profuse
b. Slight enlargement and softening of the uterus (is asymmetrical in interstitial pregnancy)	Usually	Usually	Usually
c. Adnexal (tubal) mass present	Usually present and tender	Usually present and frequently tender	Not present
d. Peritoneal irritation and tenderness in cul-de-sac region	Usually present	Frequently present	Rarely present
e. Needle aspiration of cul-de-sac through posterior vaginal vault	Always get blood	Usually get blood	Do not get blood

erable bleeding from the cervix whereas such probably would not be a prominent feature in ectopic pregnancy. Slight enlargement and softening of the uterus can be found both when there is threatened abortion and ectopic pregnancy and so may not be of much differential diagnostic value. Palpation of an adnexal mass and the presence of peritoneal tenderness would be in favor of ectopic pregnancy, while such are unusual findings in cases of threatened abortion. Finally, culdocentesis would be negative in the abortion cases, but this test is positive in practically all of the manifest and in about 85 percent of the occult ectopic pregnancy patients.

The next most common pitfall in diagnosis has been the *misinterpretation of the nature of palpable pelvic masses.* If one palpates a nodule-like enlargement of one uterine cornu, myoma is apt to be the first impession which is entertained, whereas it may well be due to an interstitial or cornual ectopic pregnancy. Sometimes an intraligamentous ectopic pregnancy can be so closely adjacent to the lateral surface of the uterus that one would be more apt to consider it a myoma arising from the lateral wall of the uterus. The firm consistency of some of the older and larger pregnancy masses, particularly when there has been some organization of their contained blood clot, can certainly cause them, on pelvic examination, to resemble a myoma.

A pregnancy involving a tube which is adherent to and curled around a prolapsed and adherent ovary can, for all the world, resemble, on palpation, merely an old, post-inflammatory, tubo-ovarian cystic mass. A developing ectopic pregnancy thus can be firmly adherent to the floor of the pelvis and may even be firmly adherent in the cul-de-sac itself. Another instance of deception is when a tubal pregnancy has ruptured quietly and gradually inside the serosal

layers of the meso-salpinx and thence on inside the broad ligament itself; since one does not expect to find a pregnancy there it can very easily be mistaken for an intraligamentous cyst.

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The following cases have recently offered difficult diagnostic problems on our service:

A CASE OF RUPTURED TUBAL PREGNANCY MISTAKENLY DIAGNOSED AS PELVIC INFLAMMATORY DISEASE

D.J., D.R.H., #13735 — 30-year-old, colored woman first seen in the Emergency Room, March 7, 1953, because of sudden onset of lower abdominal pain, principally in right lower quadrant. 6 living children, youngest 3 years old. Last mensis began February 5th. Pelvic examination revealed prolapsed, adherent ovaries, with tenderness on the right side. Diagnosed pelvic inflammatory disease, given injection of penicillin, told to return to the Out-Patient Clinic. Next seen at night in Emergency Room, March 14th, because she had been awakened from sleep by severe generalized lower abdominal pain, nausea and vomiting. Had marked lower abdominal tenderness, with rebound tenderness chiefly in the right lower quadrant. Pelvic examination revealed marked cul-de-sac tenderness and slight enlargement of the right adnexae. Culdocentesis provided non-clotting blood. Laparotomy was performed immediately, and revealed a ruptured, early pregnancy in the right tube 3 cms. in diameter and situated 1 cm. lateral to the uterine cornu. There was 300 ccs. of bloody fluid in the peritoneal cavity.

The tubal pregnancy, it can be conjectured, most probably was unruptured when she was first seen in the Emergency Room, and the adherent adnexae led to the diagnosis of pelvic inflammatory disease. Then she had gone home and 7 days later she had been awakened from her sleep by an acute lower abdominal episode which was unmistakeable for ruptured tubal pregnancy. Her true condition remained occult, therefore, until tubal rupture and hemorrhage occurred.

A CASE OF RUPTURED TUBAL PREGNANCY MISTAKENLY DIAGNOSED AS THREATENED MISCARRIAGE

L.S., D.R.H., #52-15633 — 27-year-old, colored woman admitted 11-16-52 complaining of nausea, vomiting, and lower abdominal pain, most marked on the left side. Her last mensis had begun on 9-23-52, and she had slight spotty vaginal bleeding and associated lower midline abdominal cramps on several recent occasions. She had had 2 children and 2 previous miscarriages, the last pregnancy 2 years before admission. Examination revealed mild lower abdominal tenderness, and the uterus was said to be the size of a 6 weeks pregnancy and lightly adherent in mild retroposition. Culdocentesis produced whole blood which rapidly clotted, accidental venapuncture being presumed. She was admitted to the hospital, a few hours following which she developed fever and left pyelitis. Impression was: threatened miscarriage; acute pyelitis. Patient "signed out" of hospital, returned home, had a sudden acute lower abdominal episode the following night, was admitted as an emergency case to another hospital, where laparotomy a few hours later disclosed a freshly ruptured left tubal pregnancy which was *firmly adherent in the cul-de-sac,* the pregnancy mass being 6 cms. in diameter.

One point which threw us off the track here was that the pain was experienced in the midline of the lower abdomen. Furthermore, the left adnexae were enlarged, and were adherent in the midline in the cul-de-sac. The left adnexal mass was so adherent to the posterior surface of the uterus, by old post-inflammatory adhesions, that the soft tubal pregnancy mass was mistaken for an enlarged and pregnant uterus. The culdocentesis, in retrospect, gave gross blood which clotted because the needle tapped, most probably, the maternal blood lake of the conceptus in the tube, or an adjacent pelvic vessel. The fact that the pregnancy had not yet actually ruptured made the symptoms and signs so mild as to keep the true nature of the case occult until rupture finally occurred.

A CASE OF RUPTURED ECTOPIC PREGNANCY MISTAKENLY DIAGNOSED AS INCOMPLETE MISCARRIAGE

M.N., D.R.H., #52-10562 — 32-year-old, obese, colored woman admitted from the Emergency Room on 1-11-53, complaining of increasingly profuse vaginal bleeding daily since 12-17-52, her last normal mensis having started 10-16-52. There had been sudden onset of right lower abdominal pain 2 weeks before which caused her to call her physician. He told her she had a "bad tube and ovary". There were two further similar painful episodes, the last, in which she fainted, occurring a few hours before admission. She had also felt pain in the rectum. On admission she was in shock, was pale, and her hemoglobin was 7.5 grams. Breasts were lactating (she was still nursing her 10-month infant). Abdomen extremely obese, protuberant and tympanitic, otherwise negative. Pelvic examination revealed bleeding from the cervical canal; the uterus was soft, the size of a 6-weeks pregnancy and was freely movable. The adnexae on both sides were enlarged and adherent, and slightly tender on the right. Impression: "Incomplete miscarriage, with hemorrhage and shock. Watch for possibility of ectopic pregnancy". The patient was transfused, she came out of shock, and was found to have a fever of 101°. The next day (about 8 hours later) pelvic examination under anesthesia confirmed the adherent bilateral adnexal masses, and the slightly enlarged and soft uterus. Culdocentesis, negative on admission, now yielded fresh, non-clotting blood. The gravid type of mucus plug in the cervical canal was seen to be undisturbed, and to be *in situ* and intact, so the impression of miscarriage was discarded in favor of that of ectopic pregnancy. Laparotomy was done at once, and a right tubal pregnancy, in the process of gradual abortion from the fimbriated end of the tube, was found. An old, adherent left hydrosalpinx was present, and both ovaries were adherent.

In this case the vaginal bleeding was the most prominent symptom, she was bleeding from the uterus on admission, was in shock, and her very obese abdomen was essentially negative. After admission, when she had some increase in lower abdominal pain, the clinical picture changed, and her culdocentesis test became positive.

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When one has taken a history on a woman, and has performed a physical examination (*including that of the pelvis, of course*) and the findings have raised in one's mind the question of ectopic pregnancy, the next step should be culdocentesis. This simple test can be done as an office procedure without anesthetic, and if it yields non-clotting blood then one knows that the woman has blood in her peritoneal cavity. If she is in the childbearing period of life, which, for practical purposes, should extend from the 15th through about the 48th year, then one must assume that she has a ruptured ectopic pregnancy. By far the most common cause of intra-abdominal bleeding, in the absence of another apparent source, in women in the childbearing years, is ruptured ectopic pregnancy. Long established statistics have borne out the correctness of this working assumption in hundreds of recorded cases. When the presence of free blood in the abdomen has been established in such a case, therefore, laparotomy should be performed at once.

If, in such a case, the culdocentesis does not yield any blood, one may or may not have ectopic pregnancy to deal with. If the patient's other findings are such as to indicate ectopic pregnancy, and, if in addition, there are suggestive evidences of intra-abdominal hemorrhage, then laparotomy should be performed. If the patient's condition is not acute, and the culdocentesis does not give blood, she should be kept under close and continuous surveillance while a biologic pregnancy test is performed. If this test is positive, the only remaining decision to be made is whether the pregnancy is intra- or extra-uterine. This point may be difficult to decide, but careful pelvic examination under anesthesia, and soft tissue x-rays of the pelvis, taken with the patient lying at an oblique angle on the table, may be of real help in settling this point. When, however, this question of location of the pregnancy still cannot be decided, one is faced with the proposition, if it is ectopic, that it may not rupture for several days or weeks. When such a situation exists, the physician has three choices regarding a course of further action. He has to choose between continued hospitalization and its close surveillance, the discharge of the woman from the hospital to her home (which entails inadequate coverage), or exploratory laparotomy. The course of week-after-week hospitalization is so costly these days, and the dangers of discharge so great, that, when a reasonable suspicion of ectopic pregnancy exists, exploratory laparotomy is the wisest and most feasible step.

The genesis of the "reasonable suspicion", to which reference has been made, really comes from experience with these cases. The first of two coexisting evidences which should begin to arouse suspicion in the mind of an alert physician, in a woman in the childbearing age, is the history of a missed period with some subsequent spotty vaginal bleeding; the second evidence is that of some lower abdominal pain. If such a patient has both, or even only one of these symptoms, her history should be taken in sufficiently careful detail, and her examination should be so thoroughly performed, as to permit a ruling out or a strengthening of the examiner's suspicion that ectopic pregnancy might be present. If his final impression is that ectopic pregnancy must be ruled out, then the four principal tests, culdocentesis, pelvic examination under anesthesia, a biologic test for pregnancy, and/or soft-tissue x-ray of the uterus (given in the order of their usual decreasing degree of helpfulness) should be resorted to as has been outlined.

If one follows the reasoning and steps in the foregoing there should not be much real difficulty in detecting and treating the occult cases of ectopic pregnancy. If every physician would do a careful pelvic examination on every woman who complains of any sort of lower abdominal pain or menstrual irregularities, including amenorrhoea, and if he would make himself "ectopic pregnancy conscious", even to the extent of becoming somewhat "paranoid" on the subject, our profession would not have to face the ignominy of over a hundred deaths from ectopic pregnancy in this country each year, the responsibility for which is usually chargeable to the original or principal physician seeing the patient.

SUMMARY

1. Two thirds of the cases of ectopic pregnancy are the obvious, or manifest type, and are readily so diagnosed, while the other third may have only slight or no rupture of the tube and thus may have mild and vague symptoms and signs, and in them the true condition is hidden, or occult, and the diagnosis is not easily made.

2. When a case raises the physician's suspicions that ectopic pregnancy may be present he should try to learn if the patient is or is not pregnant. If it is established that she is pregnant, then the decision must be reached as to whether the pregnancy is intrauterine or ectopic.

3. Valuable "tests" through which the riddle of the occult cases may be solved are (a) culdocentesis, (b) careful pelvic examination under anesthesia, (c) biologic pregnancy test, and (d) soft-tissue x-ray studies of the pelvis taken in the oblique axis, with or without pneumoperitoneum.

4. In the occult type of ectopic pregnancy the most frequent mistaken diagnosis, in the decreasing frequency of their occurence, are: pelvic inflammatory disease, threatened or incomplete miscarriage, myomata uteri, ovarian cyst, and intestinal obstruction.

5. A positive culdocentesis test, in which nonclotting bloody fluid is aspirated, means that there has been bleeding into the peritoneal cavity. Since ruptured ectopic pregnancy is by far the most common cause for such bleeding in women in the childbearing age, laparotomy is then indicated.

6. The history of a missed mensis, followed by some spotty vaginal bleeding, with or without lower abdominal pain, should evoke a beginning suspicion of the presence of ectopic pregnancy in the mind of the alert physician, and he should carry out her work-up so thoroughly as to rule out, or to further substantiate, this suspicion.

7. A fairly well substantiated, or *reasonable suspicion* that ectopic pregnancy is present, should make exploratory laparotomy mandatory.

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FOOD AND CANCER

In human beings, cancers already established have shown little response to dietary alterations; but in animal experiments, alternate restriction and supply of a vitamin such as riboflavin or pantothenic acid, has appreciably prolonged life. Vitamin antagonists have produced similar effects: in some children, chemical antagonists to folic acid such as aminopterin have been of temporary benefit in leukemia. Recent advances in leukemia concern certain pyrimidine compounds. When administered to animals, these drugs in combination with a folic acid antagonist appear to inhibit neoplastic growth more than antifolics alone. For nutritionists, the exploration of such antimetabolities offers rich opportunities for extending knowledge of normal and abnormal growth. *William H. Sebrell, Jr., M.D., Nutrition And Research Potentialities In Chronic Disease. Pub. Health Rep., Aug. 1953.*

Superficial Fungus Infections

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III. *Diagnosis and Differential Diagnosis*

Although superficial fungus infections of the skin are of common occurrence in temperate climates and are responsible for a goodly number of cutaneous infections, there is the distinct impression that this diagnosis is made mainly on clinical grounds and, at times, is unwarranted and erroneous.

The common sites that are frequently incorrectly judged fungus in etiology include recurrent vesicular eruptions of the hands and feet, inguinal dermatoses and eruptions of the glabrous skin where circinate scaly lesions of a sub-acute or chronic nature may be present.

The diagnosis of a fungus infection should and can be accurately established by the direct microscopic examination of skin scrapings from infected areas. The additional use of cultural techniques further add certain advantages in determining the exact species of the responsible fungus.

The methods employed consist essentially of first a direct mount. Material is taken directly from the edges of a suspected lesion or vesicle, placed on a slide to which is added a drop of a 10-20% solution of potassium hydroxide. Upon this, a cover-slip is placed, and the preparation gently heated. Microscopic examination using a high dry power objective will reveal the mycelia. Similar material dipped briefly in 70% alcohol and then placed on Sabouraud's dextrose agar slants and kept for two weeks or more at room temperature may reveal a typical colony. The gross colony characteristics and a culture mount placed in a drop of Amann's fluid (lacto-phenol cotton blue) on a slide and examined microscopically aids in differentiating the genus and species of the fungus.

Other diagnostic aids include the filtered ultraviolet light (Wood's Light) which is used mainly in infections of the scalp and in tinea versicolor. The demonstration of fungi by histologic staining methods is of limited practical value and does not lend itself to routine use. The interpretation of intracutaneous tests differ among various observers and they are considered to be of little practical value. Animal inoculations are used mainly in the diagnosis of the deep mycotic infections. Fermentation and agglutination and serologic tests are used to a limited extent in studying the yeasts.

TYPES OF RINGWORM INFECTION

a. Tinea Capitis — Ringworm of the Scalp — Tinea capitis is a fungus infection of the scalp and hair caused by various species of *Microsporum* and *Trichophyton.*

The condition is observed mainly in children before the age of puberty (M. Audouini). The infected hairs lose their luster, break off with a resultant partial loss of hair in a patchy form. Varying degrees of inflammation are present ranging from a mild scaling to a marked tissue reaction which may result in a painful elevated boggy tumefaction (kerion).

This differential diagnosis must include seborrheic dermatitis, psoriasis, alopecia areata, pseudopelade, pyodermia, folliculitis decalvans, trichotillimania and secondary syphilis.

All suspected cases should be examined by the Wood's light which will reveal a positive fluorescence in the *Microsporum* and some of the *Trichophyton* infections. Microscopic examinations of the infected hairs will demonstrate spores about the hair and mycelia. Cultures will further determine the genus and species.

The culture here is paramount in importance because some *Microspora* (*M. canis*) are easily cured, whereas *M. Audouini* or species of *Trichophyton* may require intensive and prolonged treatment. The delineation of the correct species causing the infection may be of great aid in determining the source and proper control measures.

b. Tinea Corporis — Ringworm of the Body. —Tinea corporis is caused by various species of *Trichophyton* and *Microsporum* which involve

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the glabrous skin and produce lesions which vary from those of simple scaling to deep granulomata.

This form of ringworm is characterized by one or more pea-sized, nummular or larger, circular, circumscribed, slightly erythematous, dry, scaly patches. These may not be raised above the level of the normal skin or may be slightly elevated, particularly at the border. This is usually more inflamed and more scaly than the central portion of the patch. An annular outline is thus produced and the ring ("ringworm") may extend peripherally to a diameter of several inches. In some case, concentric circles develop or rings form upon one another, making various patterns.

In another variety, there is a more emphatic tissue reaction to the fungus, characterized by vesiculation and exudation. As this inflammation spreads peripherally, circular crusted patches gradually are formed. Like the macular type, these have a tendency to clear at the center, while spreading at the periphery, so that ringed, thickly crusted lesions are produced. These lesions, as a rule, cause very little discomfort other than slight itching.

Occasionally a deep pustular type, resembling carbuncle or kerion, is observed on the glabrous skin. This is called trichophytic granuloma or tinea profunda.

Psoriasis, pityriasis rosea, granuloma annulare, neurodermatitis, annular secondary syphilis, annular lichen planus, seborrheic dermatitis, contact eczema, drug eruptions or erythema annulare centrifugum may resemble tinea corporis.

c. Tinea Cruris — Ringworm of the Groin.— Tinea cruris is an infection involving the groin, perineum and perianal region, caused by *Epidermophyton floccosum* and species of *Trichophyton.*

Typical areas are characterized by sharply marginated, elevated, papular scaly patches of dermatitis with active, spreading peripheries studded with vesicles or vesicopustules. The lesions are usually bilateral but not necessarily symmetrical. In acute cases there is considerable erythema, while older cases may show only lichenified, leathery and plaque-like lesions.

The differential diagnosis includes erythrasma, moniliasis, lichen simplex chronicus, contact dermatitis, psoriasis and seborrheic eczema.

d. Tinea Pedis — Ringworm of the Feet.— Tinea pedis is an infection of the feet, invading particularly the toe webs and soles caused by various species of *Trichophyton, Epidermophyton* and, rarely, species of *Microsporum.*

The clinical characteristics are at times widely different in appearance, behavior and response to treatment. The inflammatory type, which is usually caused by *T. gypseum,* appears on the feet in the form of vesicles on an interdigital web, on the sole or on both. These vesicles rupture readily and the skin at the site of the lesion becomes macerated and soggy. The development of fissures or cracks is common. Due to scratching and trauma, an increase in the inflammatory reaction and secondary pyogenic infection may appear. This reaction may result in the appearance of vesicles and bullae which contain cloudy or frankly purulent material. This may lead to an undermining of the entire sole of the foot with a cellulitis, lymphangitis and lymphadenitis with fever and systemic reactions. Coincident with such an inflammatory reaction on the feet, vesicles may appear at a site or sites remote from the original infection. The hands (particularly the palms and sides of the fingers) are chiefly affected. This type of eruption is due to the dissemination of products of fungi through the blood stream, and the lesions are known as "dermatophytids" or "ids".

In the chronic type there may be vesiculation or acute reaction which rather quickly developes fissures in the toe webs usually between the fourth and fifth toes, but more commonly the epidermis in the interspaces appear white, macerated and soggy. Hyperhidrosis is common and the lesions are often odoriferous. This chronic intertriginous form tends to be dormant, representing a "carrier stage".

Another chronic papulosquamous hyperkeratotic type is characterised as a rule by the absence of vesicles and pustules. The eruption most often is limited to the heels, soles and sides of the feet. The scales appear furfuraceous and branny and occur on an erythematous, thickened, patchy base which usually is well demarcated but may involve the entire sole. Hyperkeratotic plaques often develop over the heel and ball of the foot frequently in a symmetrical fashion. Such lesions rarely cause symptoms and may not be noticed by the patient.

Tinea pedis must be differentiated from contact dermatitis, pustular psoriasis, dermatitis repens, pustular bacterids, pyodermias, dyshidrosis, moniliasis, secondary syphilis and drug eruptions.

e. Tinea Unguium — Ringworm of the Nails. —Tinea unguium is a chronic infection involving the nails, caused by *Epidermophyton floccosum,* various species of *Trichophyton* and *Candida albicans.*

The nails becomes thickened, lusterless, friable, whitish or yellowish. The infection usually begins distally or at the lateral edge of the nail. In some instances the top of the nail separates distally, leaving it thin, furrowed, ragged and deformed. The patient usually gives a history of previous infection of the toes, feet or hands; toe nails are affected more often than finger nails, and one or more nails may be affected. Paronychial involvement is uncommon except in infection due to *C. albicans.*

The differential diagnosis of tinea unguium includes psoriasis, onycholysis, acrodermatitis perstans, paronychia congenita and dystrophy following pyogenic infections of the paronychia.

f. Tinea Versicolor.—Tinea versicolor which is caused by *Malassezia furfur* is a chronic superficial disease characterized by fawn to brownish-colored desquamating macules involving principally the trunk. Occasionally the axillae, groin, arms, thighs, neck and face and scalp are affected.

On the trunk the lesions of tinea versicolor are superficial, and appear as irregular, circumscribed, brownish-red, furfuraceous patches. Such lesions fluoresce under the Wood's light.

In some instances, pseudoachromia, resulting from screening from sunlight or a possible toxic inhibition of pigment formation, is a feature of the infection.

A direct mount of scales from the brown colored macules will reveal the fungus as clusters of thick-walled, round and budding forms surrounded by short, straight and angular fragments of mycelium. Routine cultures are not made because *M. furfur* cannot be grown on artificial media.

The infection must be differentiated from seborrheic dermatitis, erythrasma, secondary syphilis, pityriasis rosea, cholasma and vitiligo.

g. Other Ringworms.—There are several types of superficial fungus infections which although important are of rare occurence in this climate and are not included in this review. These include favus caused by *T. Schoenleini.* Tinea barbae which is mainly caused by *T. gypseum,* erythrasma due to *Actinomyces minutissima* and others.

In regards to moniliasis which is caused by *Candida albicans* (*Monilia*) the clinical pictures are so varied depending upon the location of the infection that they will be discussed at some other time. I have, however, taken the opportunity to present illustrations of monilial infections where they play a role as a differential diagnositic possibility in a superficial fungus infection.

SUMMARY AND CONCLUSIONS

Superficial fungi are responsible for a large number of cutaneous eruptions. It is recommended that demonstration of the etiologic agent be done before treatment is instituted. If a therapeutic test is unsuccessful, it is mandatory to review the case, with appropriate laboratory assistance.

A review of the salient features of the more common superficial fungus infections and some of the differential diagnostic possibilities are presented.

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Operative Dentistry for the Cerebral Palsied and Difficult Child Patient Under General Anesthesia

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Review of Patient's Psychological Patterns.— Fear is one of the most important emotions that we have. In its place, it is a valuable response. Out of place, it is most destructive. Since today most fears are out of place their mastery is extremely important. The term "anxiety" is closely related to fear as we deal with it. The anxious person is in a continual state of morbid dread. This dread attaches itself to everything that has a bearing on the life of the patient.

It is the ambition of all dentists to practice their profession with the shortest, quickest, most reliable and most effective means of preventing emotional reactions in his patients without interfering with performing good dentistry. But modern dentistry demands more than a skillful practitioner - it demands the practice of the art of dentistry.

Dentists are all familiar with the psychological effects which environment can have on the patient, as illustrated by the proper arrangement of office equipment, provision for agreeable odors, tastes, and sounds such as music, and so on. This type of indirect influence on the perceptual level is an important part of dental psychology; but, of course, only a first step. The more essential consideration is the personal relationship that must be built between the dentist and his patient.

Each patient has a distinct personality, and the dentist must be prepared to deal with his emotional reactions as well as his diseased tissue and carious teeth. For the emotionally stable patient, the ordinary concepts of the art of dentistry are sufficient; but what about those many thousands of children and adults who may be classified as nervous patients? We have to think of those people whose emotional reactions are exaggerated — as people who have not yet grown up psychologically. Their personality development in this respect has been retarded or arrested at some childhood or even infantile level of growth. They are more sensitive and react in a more intense degree to external irritations than average people. It is unfortunate that some dentists have an attitude of contempt or impatience toward patients of this type. For these patients, the art of dentistry must go beyond our commonly accepted standards.

In our opinion, general anesthesia has answered this challenge through the application of drugs and gases which give the patient reassurance; in other words, aids to create in the patient a sense of relaxation and ease. This reassurance is further exemplified by the fact that, in this type of patient, in our office, all the operative dentistry is accomplished in one operation. Why not? Does the surgeon remove our gall bladder in four or five sittings?

The Difficult Child. — Due to the brevity of this paper, I dedicate the first phase of this article to "the difficult child". The screaming, kicking, frightened child, who refuses to respond to reason, coaxing or kindness, is well known to all of us. The child's mother invariably gives a history of visiting many dental offices without definite treatment being carried out due to the child's behavior in resisting all therapy.

At this point they are usually referred to our office. On the first visit, the patient receives an oral examination. X-Rays are attempted; however, if impossible on the first trial, they are deferred until during the induction stage of the anesthetic. A history is taken from the very confused mother, and a date for the operation is made.

Anesthesia Technique. — The patient reports to the office one hour before the medical anesthesiologist for their pre-medication, which usually is Atropine sulphate and morphine, or one of the barbiturates.

After one hour of resting in our post-anesthetic room, the child is given a chest and cardiac examination by our physician and is then wheeled

into our office operating room which, from a standpoint of anesthesia equipment, has been duplicated in every way from the most modern hospital, including a medical anesthesiologist.

The child is placed in the chair, and the nasal piece is removed from the gas machine. I blow a mixture of nitrous oxide and oxygen through the black hose in the patient's face, at my nurse, at me; in other words, it is a big joke to the patient as "sweet air" being blown through "Mommy's vacuum cleaner", as so many of them have typed this technique. Enough of this direct blowing in the vicinity of the face makes the patient fall asleep naturally, with no bad memory of a large piece of rubber material "suffocating" them to sleep.

At this phase, our anestheiologist takes over and replaces facemask to hose and induction proceeds with Nitrous Oxygen and Trichloroethylene as a synergetic agent to give a balanced anesthetic to assure us that the normal oxygen content of the blood is maintained throughout the anesthetic. On long cases the Trichlorethylene is shut off and is supplemented with ether. The rebreathing bag is emptied several times during induction to remove the nitrogen from the mixture. Pulse, blood pressure, and respirations are recorded throughout the anesthetic.

When the patient is ready for treatment, the face mask is replaced by the nasal inhaler; and the patient is either put on a semi-closed system of nitrous oxide, oxygen, and ether, or closed system of ether and oxygen. This decision is made by our anesthesiologist based on the patient's physiology.

Mouth props are then placed in the mouth, the tongue is pulled forward, and moist throat packs are placed at the posterior region of the oral cavity. A heavy duty aspirator must be used to pick up tooth debris and blood.

Cavity preparations are started on one segment of the mouth. They are done with the aid of cold water to prevent pulp damage. As no real time limit is placed on me, my attention and efforts are drawn to well-prepared cavity preparations and the usual cement bases and finally the finished amalgam.

We then move to other quadrants of the mouth until all operative dentistry is performed. Pulpotomies are encouraged in this technique as a dry relative sterile field usually gives us a good margin of success with this type of operation. All extractions and oral surgical procedures are left to the end.

After all operations are completed, the throat packs are removed and the pharynx is examined by the aid of a laryngoscope. Any blood or debris is suctioned from the throat. The child is then placed on 100% oxygen for ten minutes, and is then removed to our past anesthetic room where blood pressure, pulse and constant attention is given the patient during his emergence from the anesthetic.

Problems Surrounding The Cerebral Palsy Patient. — The next group to consider is the Cerebral Palsy patient, of whom someone has called them "the forgotten children". Five-hundred thousand individuals are estimated to be victims of Cerebral Palsy in our nation. Ten-thousand children are born each year with this condition. This is a condition as we know it where muscular control is impaired or lost. The etiology varies from injury to the brain tissue during difficult birth, to variations in the developmental structures of the brain. When damage to the brain is inflicted, little can be done, but the patient can be helped to overcome some of his disabilities by various therapeutic methods, viz., physio-therapy, psycho-therapy, surgery, speech training and drug therapy.

Types vary also from spasticity, which accounts for fifty percent of all the cases, athetosis, in which constant involuntary movements occur, accounting for thirty-five percent of cases, ataxia, where there is inability to retain balance and hold posture; and, finally, tremor, and rigidity complete the group.

The lact of motor control in these children makes it very difficult for them to maintain adequate oral hygiene and for the dentist to carry out the necessary dental treatment. And it is to this type that I dedicate the second portion of my paper.

In our experience in the past five years, wherein we have seen all cases mentioned above many times, we have found a great deal of inflammation and hypertrophy of the gum tissue. We have also noted deformities of the dental archs and malocclusion due to the abnormal musculature. Carious teeth were found to run high due to the lack of motor control and lastly grinding of the teeth by involuntary movements

added to the very poor oral condition of these patients.

Again, I ask you: Are we to let these poor patients rack with pain or to make their already dark confused life more untolerable? Dentistry for the cerebral palsied child is still in its infancy, so for the busy dentist it seems only proper to encourage this patient to submit to general anesthesia and have all dental procedures completed at one sitting.

Our technique is different in this group of patients. We use sodium pentothal for induction. This is a two-and-a-half percent solution and is injected intravenously. A 3 cc. solution of curare is also used. This is most important to the spastic patient, as it gives us extra relaxation and decreases the amount of sodium pentothal needed to get the patient in a surgical relaxed stage.

If the operation is expected to exceed fifteen minutes, we insert a naso-pharyngeal tube at the point of the disappearance of the eyelid reflex. This must be approached with reservation. A markedly deviated septum or enlarged turbinate may prevent the proper insertion of the tube. Pentothal anesthesia is supplemented by a fifty percent nitrous oxide oxygen mixture delivered through an ordinary dental nasal mask. Again, a heavy duty aspirator along with proper throat packs should be used to prevent aspiration of bone fragments and blood into the throat.

The same post anesthetic procedure is employed as stated above, except that 3 c.c.'s of Metroze® is injected through the same needle and vein into the patient at the close of our dental procedure to hasten his anesthetic recovery period. On all long cases, the use of fluids, dextrose 5 percent in water is usually used from induction period until the patient is ready to go home. One out of three mothers cry with joy as they see the child recover so beautifully and realize their child, after many years of neglect, can now have the same fine dental care that the normal child receives.

In our normal but obstreperous child, when returning for future dental work, submit to my suggestion to try and have the teeth drilled without going to sleep. Many permit me to do so, making it obvious that *general anesthesia* has served to break the anxiety fixation in their mind and has restored them to normal emotional individuals.

CONCLUSIONS

The employment of proper psychotherapeutic technique and anesthesia becomes particularly important in the practice of dentistry for children. Dentists cannot evade their professional responsibilities by giving disinterest or dislike as an excess for deficiencies in dealing with young patients.

In this brief paper, I have tried to outline two aspects of the many in the practice of dentistry where the art of dentistry is the more important aspect in the case of patients who visit our offices. It is a matter of personal pride that each of us believe that our knowledge and technical dexterity is modern and up to date; and, as practitioners of the science of dentistry, each of us feels we are without peer. However, let us not in our egotism regarding our scientific and technical accomplishments be blind to those patients who seek and deserve special consideration of their problems. The satisfaction of a job well done and the gratitude of these patients makes the small sacrifices in extra time, effort and consideration worthwhile.

The Role of the Police Scientist in a Medical Legal Investigation

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Everyone knows that in the majority of homicides, accidental deaths, or deaths under suspicious circumstances, the police are first to contact the problem, and all too frequently the pathologist arrives after the investigation is well under way. We know that academically the pathologist is required only to ascertain and report the immediate cause of death, yet any experienced medico-legal expert admits that often his diagnosis is held in abeyance until certain questions which can be resolved only by a study of the "associated evidence" have been answered. Therefore, the integration of the police scientist into the scheme of an orderly medico-legal investigation is important.

For practical purposes our observations begin with the initial report of the offense and the arrival of a police officer. Important happenings which may influence the ultimate decision are not considered now. Imperative as it is that a medical examiner observe the body of the victim before it has been moved, we know that this procedure is followed, or is operationally practical, in only a small percentage of the cases. In the absence of this personal examination of a crime seene, the medico-legal expert must rely on the impressions of witnesses and police officers, the latter usually being more reliable because of their training and experience. Common methods of recording a crime scene include notes, field sketches, scale drawings, photographs and models or three dimensional replicas of certain forms of evidence. While the measurements aceompanying sketches are important, photography of the highest order is the most valuable part of this preliminary work. It is impossible to overemphasize the necessity for forensic pathologists to have a detailed record of the exact relation of the body to its surroundings in addition to the minutely detailed picture of the victim. In many cases crime scene photographs have been studied for hours in an attempt to reconcile laboratory findings with facts surrounding the diseovery of the crime. To illustrate, the victim of homicide had been transported in the trunk of the assailant's car. The body was subsequently deposited in a rocky ereek bed where it was discovered. Several officers examined the body but failed to notice two circular impressions on the left hip of the victim. A crime scene photograph clearly revealed the tell-tale marks which were determined to have been caused by the body resting on the hubeap of a spare tire in the trunk. Incidentally, these impressions were not apparent when the body was later examined in the morgue by a medieal examiner. The body had been virtually drained of blood thus accounting for the lack of post mortem lividity.

Police scientists should be thoroughly acquainted with all photographic technics necessary to the proper recording of a crime scene. The forensie pathologist should advise the police laboratory photographer exactly what types of photographs are helpful and thus avoid the disappointment and irritation which usually comes with the average crime scene photograph.

Following the recording of the crime scene the second, and probably the most important step in the investigation is begun. This is the collection and preservation of evidence. While most police officers are aware of the importance of this phase of a criminal investigation, it is particularly encouraging to note that several medico-legal experts have prepared papers on this subject. Accounts of the investigations of recent disasters such as Coconut Grove, Texas City, Ringling Bros. Circus and Noronic fires are the best evidence of the need for a proper understanding of this subject.

Read at the joint meeting of North Central Region College of American Pathologists, Illinois Society of Pathologists and American Academy of Forensic Sciences. Dec. 6, 1952. Chicago, Illinois.

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Some of the more common types of physical evidence include stains (blood, seminal, fecal, other body fluids, oil, grease, paint, food and miscellaneous), clothing or fragments thereof, fibers, fragments of paint, glass, metal and wood, fingernail scrapings, soil samples, the vast number of chemicals, both solid and liquid, toxic and non-toxic and those classified as drugs or narcotics, hair both human and animal etc. In fact, evidence is defined as anything which proves or disproves the validity of the statement in question. There is little or no similarity between the identification of the above types of evidence and the recognition of fat emboli in a tissue section. Yet, proper evaluation of this type of evidence is just as important as a decision which states that an individual was dead before or after being placed in a room which was destroyed by fire. It is fantastic to assume that the forensic pathologist is expert in the scientific skills necessary to conduct examinations admittedly outside of his field, and it is equally preposterous to suggest that one police scientist is equipped to perform all pertinent examinations. Herein lies sufficient reason to justify, even demand, the creation of a recognized branch of a medicolegal investigation which may be called police science and which is not to be confused with police administration, criminology, criminalistics, etc.

The dangers of venturing outside of one's own field of specialized knowledge are apparent to the forensic scientist, yet it is far more alarming to see evidences of faulty, pseudoscientific testimony introduced into a court of record. This fact becomes more appalling when we consider that the potential life or liberty of a fellow human rests in the balance. I have read some of the reported scientific testimony examined by the Court of Last Resort in review of cases wherein a miscarriage of justice is suspected. No one would be proud to claim authorship to some of the statements reviewed in the dispassionate light of an objective analysis of the facts, 5 to 15 years after the trial.

In several areas a trained police scientist can offer invaluable assistance but in three fields, especially, conflicting opinions are expressed by witnesses. First of these is the matter of powder burns incidental to a gunshot wound. Questions are raised about the distance between the muzzle of the gun and entrance wound in the body, the presence or absence of powder burns, the spatial distribution of powder particles and the nature of metal particles which may or may not be present. Unquestionably the pathologist must report on the nature and appearance of the tissue surrounding the wound, but any further remarks should be supported by the results of a chemical isolation and identification of powder residue, panchromatic and infra-red photographs of the area in question and possible x-ray and / or spectrographic analysis of metallic substances.

Secondly is the dermal nitrate test to determine whether or not a subject may have fired a gun recently and which is either the target of enthusiastic support or of positive denunciation. Innocent people are subjected to interrogation, arrest, arraignment and trial, with results of a carelessly done diphenylamine test as the principal shred of evidence. At the opposite extreme many responsible agencies refuse to consider it as an investigative aid. However, the medicolegal expert should include this technic in his procedure and use it in manner consistent with its limitations.

The third field is the determination and interpretation of alcoholic intoxication. Admittedly, this problem is of greater importance to the living than to the dead, but more contradictory, and frequently non sensical, scientific or expert testimony is offered about this problem than any other legal question under scientific investigation. Because this field of investigation involves chemical, physiological and psychological understanding, and because it is associated with a large percent of our criminal cases, a close working relationship between the medical examiner and the police scientist are essential.

Many have mixed feelings about the value of a police laboratory or police scientist. We all know that the greatest need for improvement lies at this bottom, yet highly important rung of the ladder. With a few exceptions, the police scientist of the past, has been a self-made expert. In fact, police science as such in the United States began in the City of Chicago in 1929 as a direct result of the St. Valentine's Day massacre. At present, the University of California, Washington State College and Michigan State College are offering four year undergraduate programs in police science. These programs are

attempting to acquaint the serious student with the basic technics essential to a police laboratory.

The departments are also engaged in research programs, which are so necessary to the development of any science. There are many problems of course content, emphasis of certain technics, adequate background preparation, accrediting of programs, etc. But more important is the necessity of convincing our police administrators that a laboratory technician must be well trained, adequately paid and properly integrated into the orderly scheme of efficient scientific criminal investigation. The American Academy of Forensic Sciences understands that such a program is necessarily a long range endeavor and measures must be taken to improve the existing conditions. To accomplish this, the Academy is devoting much time to a survey of the problems which are most apparent. Forgetting for a moment the financial side, a clear cut definition of the boundaries of police sicence is most important. Here, scientists in other forensic fields must cooperate in the division of responsibilities. Some medical examiners feel that the identification of a seminal stain is rightfully within their scope of activity, while others refuse to include this particular examination in their laboratory routine. Once the limits of the field have been established, training and qualifications must be considered. Here, the Society for the Advancement of Criminology, which is the organization currently representing the colleges and universities offering police science programs becomes the logical group to assist in the establishment of minimum standards for our teaching efforts.

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NEW TOOLS FOR CANCER

During the past few years, with the development of improved working tools such as the micromanipulator for single cell studies, electron microscope, phase microscope, television microscope, improved photomicrography, and moving pictures, as well as better staining and other cytologic techniques, it is possible to demonstrate convincingly that variations in morphology are not necessarily "atypical" or "degenerative" but in some organisms seem to follow a developmental and growth pattern which can repeat itself over and over if conditions permit. Kahn's meticulous single cell technique demonstrated that under some conditions the tubercle bacillus does not undergo binary fission but increases by breaking up into many minute granule bodies from which sprout tiny, hairlike new rods. *Virginia Wuerthele-Caspe. M.D., et al., Some Aspects Of The Microbiology Of Cancer. J. Am. Women's A., Jan.* 1953.

CASE REPORTS



Metastases to Bone from Bladder Tumors

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When considering metastases from tumors of the bladder, we think first of local extension into the paravesical and retroperitoneal lymph nodes. It is not generally recognized, however, that extension by the blood stream to other organs, particularly the liver, lungs, and bone, is common and may occur at any stage of the disease. The older concept of the infrequency of bone metastases from bladder tumors still prevails. Secondary extension is common and bears no relationship to the degree of infiltration or the size of the primary vesical neoplasm.

The carcinoma registry on the American Urological Association in 1934 showed the incidence of bone metastases to be 3.7 per cent of 902 bladder tumors; and 3 per cent of all tumors showed metastases with 47 per cent of these to bone. Routine x-ray surveys on all patients with bladder tumors would undoubtedly reveal a much higher incidence of metastases.

Colston and Leadbetter, in 1936, found metastases in 61.1 per cent of 98 cases. Many represented end stages of the disease, but others did not. They reported that after retroperitoneal gland involvement, the most frequently involved organs were liver, lungs, and bone. Bone involvement was found in 18.1 per cent of their cases; liver, in 41.8 per cent; lungs in 25.4 per cent; and lymph glands in 72.7 per cent. In their series, most of the cases were papillary. Some were small and showed no evidence of infiltration even at death. Metastases took place when lesions were small and apparently amenable to therapy. Kretchmer and McDonald reported a similar series in which they again stressed the frequency of bone involvement, particularly the fact that it may arise in any stage of the disease and seems to have no relationship to the degree of infiltration of the primary tumor. Spooner found metastases in 49 per cent of 163 cases. The liver was the commonest site of involvement followed in order of frequency by lungs, bone, adrenals and kidneys. He observed that distant metastases have been noted in the absence of local lymph gland involvement or direct extension to contignous organs. In 1918 Geraghty stated that bladder tumors may be extensive and deeply infiltrating without metastases, but there may be metastases in malignant papillomata without the slightest infiltration of the bladder wall. When metastases occur, spread to bone seems to be frequent. The fact that extension from bladder tumors may be to distant organs

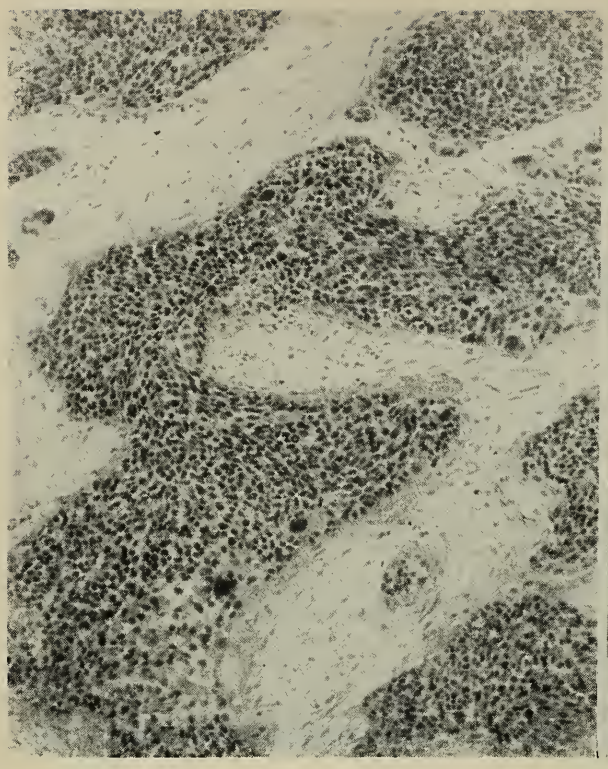


Figure 1. Photomicrograph illustrating the structure of the carcinoma in the urinary bladder.

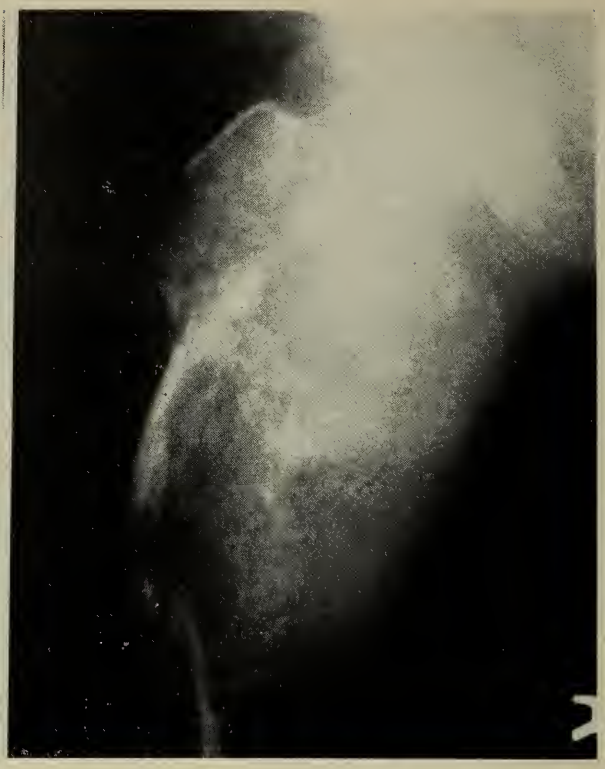


Figure 2. Photograph of Roentgen film illustrating the extensive distruction of the upper end of the right femur.

and may occur at any stage of the disease without relationship to the degree of infiltration seems to indicate that in a large percentage extension is through the blood stream.

Case Report.—Mr. L.B., aged 49, was first seen July 16, 1949, complaining of painless hematuria which had existed over the past year and had been constant for the past three months. He had mild frequency and nocturia, once nightly. Past history was noncontributory. Physical examination was essentially normal. The blood pressure was 135/70, the chest was clear, and the cardiac rate and rhythm were normal. Liver, kidneys, and spleen were not palpable, and his prostate was normal in size, shape, and consistency. The expressed secretion contained 15-20 exudate cells per high power field. Bimanual examination failed to reveal any mass or paravesical infiltration. The urine was bloody. Cystoscopy revealed an irritable bladder and a large edematous papillary tumor covering the right half of the floor of the bladder which extended into the trigone (Figure 1). The right ureteral orifice was obscured by the tumor. Several necrotic foci had small adherent clots. Intravenous urogram showed a normal left kidney and ureter. The right kidney and ureter failed to visualize and a large filling defect was noted in the bladder.

The patient was discharged on February 17, 1950, on the 13th postoperative day. Pain was alleviated but not eliminated. The patient was ambulatory, but gradually lost weight and strength.

On March 17, 1950, eight months following surgery, the patient felt a snap in his right leg and fell. He was again admitted to the hospital and placed in traction. X-rays showed a pathologic fracture of the right upper femur and extensive destruction of bone (Figure 2) which was not apparent on X-ray six weeks prior.

The patient rapidly grew worse and died on April 5, 1950, nine months following his first admission.

The autopsy showed the following: The left kidney was normal. The right kidney was contracted and weighed 100 grams. There were depressed scars on the cortex which caused a marked nodularity. The cortex was narrowed and distorted, the pelvis thickened and the right ureter was slightly dilated. The urinary bladder was contracted and an ancient well healed scar was seen on the floor. The right ureteral orifice was partially occluded by a lobulated, firm, smooth, yellow-grey villous mass, 10 by 5 by 5 millimeters which extended 1 centimeter into the lumen of the ureter. The bladder wall was flexible throughout and no tumor tissue was seen in the paravesical areas. The prostate and seminal vesicles were normal. The retroperitoneal glands were not involved grossly or microscopically. A large reddish, soft, necrotic and bloody tumor mass was at the site of the pathological fracture of the upper third of the right femur (Figure 3).

The microscopic diagnoses were:

A. Recurrent transitional cell carcinoma of the lower end of the right ureter.
B. Metastatic carcinoma of the right femur and tibia.
C. Right chronic pyelonephritis.
D. Pathologic fracture of the right femur.
E. Bronchopneumonia.



Figure 3. Photomrcrograph illustrating the metastatic carcinoma tissue in the upper end of the right femur.

Discussion: A case of blood borne metastases from a bladder tumor to bone is presented. Tumor cells of the primary lesion probably entered the blood stream and were carried to the bone. Bony metastases present at the site of pathological fracture 2, shortly after was followed by an extensive, destructive lesion of the femur.

CONCLUSIONS:

A. Metastasis to bone from bladder tumors is more frequent than is generally known.
B. Most tumors of the bladder are papillary.
C. Metastases are apparently blood borne and bear no relationship to the size of the primary tumor.
D. The bony lesions are osteloytic in nature.
E. Radical surgery with removal of pelvic lymphatics is an advance, but is not the final answer to treatment of carcinoma of the bladder.

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SHIRKING

There are lots of things in the practice of medicine about which we are conscious, and about which we sense there may be some importance. But we have not crystallized our thinking of them into concrete opinions that would determine or direct any action, if action were needed. Indeed, how complacent we are! In the face of a growing incidence of lung cancer we permit the dragging in of the doctor-acceptance advertising of the cigaret manufacturer. A "big play" has been made to use the honorable prestige of a profession to fake an endorsement yet we have stood for this sort of thing without a murmur. *Editorial. Pennsylvania M.J., May 1953.*

THE HUMANITIES IN MEDICINE

In spite of the fact that it has been brought to the attention of the profession for at least a hundred years, it is only recently that we are beginning to realize that warm human understanding of an individual can sometimes do as much toward curing disease as all the drugs and surgery at our command. This is a particularly important concept for the young physician to remember. Too seldom does he realize that his splendid scientific education gives him only part of the basis for medical practice. In actuality he is ill equipped to practice medicine when he graduates from medical school. *Paul Williamson, M.D., The Humanities in Medicine. Pennsylvania M.J., June 1953.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Wesley Memorial Hospital
Edited by R. R. J. Hilker, M.D.
Chicago

CASE NO. 3251

CLINICAL HISTORY

This 62 year old white male laborer entered the hospital with the complaints of. 1) weakness for eight weeks, 2) pain in the abdomen for three weeks, 3) swelling of the ankles for three weeks.

Present Illness: The patient was perfectly well until 8 weeks prior to admission to the hospital. At that time he noted gradual onset of weakness, which became progressively worse so that he was forced to change his occupation from heavy manual labor to dishwashing. About six weeks before admission he became unable to work at all. Three weeks before admission he visited his local physician. This physician manipulated a lump in the patient's epigastrium which had been present and asymptomatic for 20 years. Subsequent to this manipulation the patient noted non-radiating colicky postprandial pain in the region of the lump. The pain was not relieved by change in position or by sodium bicarbonate. In fact, the pain became worse following the administration of sodium bicarbonate. There was no history of dysphagia, anorexia, nausea, vomiting, change of bowel habits, food intolerance, bloody or tarry stools or flatulence. Pedal edema was first noted approximately three weeks prior to his admission. This occurred daily in the late afternoon or evening and disappeared after night's rest. He had no shortness of breath or orthopnea.

There was history of a 25 pound weight loss in approximately the last two or three months.

Past And Family History: Non-contributory

Physical Examination: Physical examination revealed a pale, weak, elderly white male who appeared chronically ill. The temperature was 97.8 degrees F., the pulse 92 per minute, and respirations were 20 per minute. The blood pressure was 116/70 mm. Hg. The neck veins were slightly distended. The teeth were carious. The chest was emphysematous, and the lungs were clear to percussion and auscultation. The heart was not enlarged. A grade I systolic murmur and a split first sound were heard at the apex. The abdomen was flat. There was a soft tender, irreducible midline epigastric mass which protruded slightly more with increased intra-abdominal pressure, and which measured 3.5 cm. in diameter. A non-tender smooth liver edge was palpated 4 finger-breadths below the right costal margin on deep inspiration. There was 1-plus pitting edema of the feet and of the lower legs. Neurologic examination revealed a slight left facial weakness, a positive Hoffman sign on

the right, and bilaterally hypoactive deep tendon reflexes.

Laboratory Data: On admission the urine was normal except for an occasional red blood cell and 30 mg. of albumin. Hematologic examination revealed 5.4 gm. of hemoglobin per 100 cc. with 1,900,000 red cells and 7,900 leukocytes per cu. mm. There were many target cells and some anisocytosis and poikilocytosis. The differential count was 55% segmented neutrophils, 12% unsegmented neutrophils, 31% lymphocytes and 2% monocytes. The hematocrit was 20. The corrected sedimentation rate was 7 mm. per hour. The platelet count was 46,920 per cu. mm. There were 3.9% reticulocytes. The prothrombin time was 100 percent of normal. The bleeding and coagulation times were within normal limits. The Kahn test was negative.

The fasting blood sugar was 93 mg. per 100 cc. The non-protein nitrogen was 25.8 mg. per 100 cc. The serum proteins were 6.18 grams per 100 cc. with 2.76 grams of albumin and 3.42 grams of globulin. The serum phosphorus, alkaline phosphatase, and acid phosphatase were normal. The Van den Bergh revealed a heavy trace of delayed reaction. The thymol turbidity was 2 units. There was 10% retention of bromsulphalein dye after 45 minutes.

Examination of the stools for ova, blood and parasites was negative. A proctoscope was passed to 24 cm. and nothing abnormal was seen. Gastric aspiration after subcutaneous injection of histamine revealed free acid. X-ray examination of the chest revealed shadows interpreted as calcification of the aorta and a 25 percent increase in cardiac diameter which was mainly left ventricular enlargement. A scout film of the abdomen showed only hepatomegaly. X-ray examination of the upper and lower gastro-intestinal tract was normal. An intravenous pyelogram was normal. An electrocardiogram showed sinus tachycardia but was otherwise within normal limits. Funduscopic examination revealed arteriosclerotic retinopathy, Gifford II, and senile macular degeneration of the left eye. The Rumpl-Leeds test was positive. Examination of the peripheral blood for L. E. cells was negative.

On the seventh hospital day a sternal puncture was done and was repeated two weeks later. The results were as follows:

	Normals	*First Study*	*Second Study*
Nucleated cell count	10,000-190,000	16,150	37,000
Blast Cells	0.5%	2.25%	5.50%
Granulocytic series	33-64%	42.50%*	42.50%+
Monocytic series	0-5%	0.25%	1.75%
Plasmocytic series	0-2%	1.00%	4.00%
Megakaryocytes	0-2%	Occasional	0.75%
Erythroid series	6-39%	25.25%‡	19,00%++

*Mitotic forms and occasional giant cells seen. Many atypical granulocytes present.

‡Many fragmented and mitotic nuclei-marked anisocytosis, and poikilocytosis.

+Atypical neutrophilic cells present similar to those seen in first study.

++Many fragmented nuclei and disintegrated cells. Marked anisocytosis and poikilocytosis.

The tuberculin, histoplasmin, and coccidioidin skin tests were negative. Numerous bacteriological examinations were carried out, starting when the patient was admitted to the hospital and continuing through the course of his illness. These include examinations of sputum, gastric washings, blood, bone marrow, lymph node, bronchoscopic aspiration, urine, and pleural fluid. No tubercle bacilli, fungi, or any other pathogenic organisms were found. Thoracentesis fluid revealed no tumor cells.

On two occasions the urine showed a faint turbidity on heating which partially clarified on further heating. The turbidity increased again on cooling. On several occasions addition of 20% ferric chloride to the urine resulted in a heavy dark gray precipitate.

Hospital Course: During the first two weeks in the hospital the patient had an intermittently elevated temperature rising as high as 101 degrees F. In spite of penicillin and blood transfusions, his general condition gradually became worse and on the 15th hospital day rales were heard in the lungs. X-ray of the chest revealed rounded densities in the lower part of the right hilum

which strongly suggested "hilar adenopathy". Successive X-rays showed progression of this lesion to involve the lower, then the upper lobe of the right lung, and on the 37th hospital day infiltration of all lobes of both lungs were noted, as well as fluid in the right pleural space. Fever continued in the same irregular fashion but at higher levels up to 103 degrees F. Biopsy of an axillary node on the 26th hospital day revealed fibrosis and hyalinization. Bronchoscopy on the 30th hospital day revealed only bilateral "acute endobronchitis" of undertermined cause, and cytologic study of bronchial aspirations showed no tumor cells.

A mass recurred in the area of the lymph node biopsy two weeks post-operatively. This was removed and showed on pathological examination subacute and chronic inflammation and fibrosis of fibroadipose tissue. Post-operatively this wound disrupted and became infected with E. Coli.

Peripheral blood studies during the course of his illness showed platelet counts varying from 16,730 to 45,800. His hemoglobin was never over 9.8 grams per 100 cc. Reticulocytes varied from 1% to 5%. His white blood count varied from 5300 to 9300 cells. The differential white count showed only immature neutrophils. On the 45th hospital day the differential white count was as follows: segmented neutrophils 19%, band cells 24%, metamyelocytes 10%, myelocytes 1%, lymphocytes (mature) 30%, lymphocytes (early and atypical) 10%, plasma cells 1%, monocytes 4%, pro-monocytes 1%. This was the only grossly abnormal differential count recorded.

In spite of the treatment with vitamins, vitamin B-12, penicillin, dihydrostreptomycin, para-aminosalicylic acid, and isonicotinic acid, the patient's condition steadily became worse. The rales in the chest gradually increased until there were moist rales extending throughout the lung fields. The patient was digitalized but he died on the 53rd hospital day.

CLINICAL DISCUSSION

Dr. Gilbert H. Marquardt:* This case presents a definite challenge. In reviewing it we will go through the protocol briefly. This patient presents the story of a lump in the epigastrium which became painful after manipulation. The 20 year history cetrainly speaks for something benign. I would suggest that this lump was most likely a ventral hernia, although the possibility of a lipoma or a fibroma must be considered. The pedal edema is a striking feature in this case, and may fit with cardiac decompensation. However, such other causes as nephritis or nutritional edema must be considered. The history of a 25 pound weight loss in two or three months is impressive and certainly would suggest some serious debilitating disease. It is not surprising to find an apical systolic murmur of the character noted in a patient with this degree of anemia. However, this murmur may have some further significance. Unfortunately we have no progress notes in the history concerning this murmur. The split first sound heard at the apex may be due to a heart block. However, the normal electrocardiograph rules this out. The liver is said to be enlarged to about four finger-breadths below the right costal margin. A four finger breadth span is approximately 6 cm. However, this statement is not complete unless we are able to state the position of the upper margin of the liver. This is not noted in the history, therefore we are unable to say that the liver is enlarged. The impressive thing about the laboratory examinations is the marked anemia, and also the low platelet count. The Rumpl-Leeds test in this case is not a matter of much significance. Probably the most significant laboratory finding presented is that of the Bence-Jones proteinuria. Dr. Cannon, would you show the x-rays and perhaps tell us how you measure liver enlargement by x-ray?

Dr. A. H. Cannon: On our first film of the chest we can see that there is some increase in the transverse cardiac diameter. The lungs are entirely clear. On the abdominal film the lower margin of the liver appears to be in a position compatible with an enlarged liver.

Dr. Marquardt: Why do you think the liver is enlarged?

Dr. Cannon: Because it is hanging down a little lower than we usually see it. We normally consider the liver shadow to be enlarged when it is more than the span of one hand.

Dr. Marquardt: Thirteen days after the initial x-ray examination there is a re-examination of the chest. Now we see a density in the right hilar area which was not present on the other film. Otherwise there is no particular change in

*Attending physician Wesley Memorial Hospital.

the chest. X-ray films a week later begin to show infiltrations in the right upper and lower lobes. The next x-ray examination 11 days later shows a remarkable change in the chest. There is a progression in the infiltrative lesions and one gets the idea that the upper lobe is beginning to collapse. There is also infiltration in the left lung at this time. There are no lesions in the ribs. Later x-ray examinations of the lungs are similar except for a small amount of fluid in the right pleural space. No x-rays of the spine were taken. Perhaps Dr. Cannon could tell us how much fluid must be in the pleural space before it is visible on x-ray examination?

Dr. Cannon: A satisfactory x-ray visualization of pleural fluid can be obtained when from 175 to 200 cc. of fluid is present.

Dr. Marquardt: The x-rays in this case are not particularly helpful. All they tell us is that there is some infiltrative process in the lung fields, and I would say that this has many characteristics of tumor. However, the differential diagnosis must include inflammation as well as tumor. The infectious diseases such as tuberculosis, sarcoidosis and histoplasmosis might cause nodular densities in the lungs. Tumors which must be considered are carcinoma, either primary or secondary, lymphomas, Hodgkin's disease, leukemia, including plasma cell leukemia, and multiple myeloma.

First let us consider tuberculosis. Much of the clinical evidence in this case points to tuberculosis, but many gastric washings and sputum specimens were negative for tubercle bacilli. In spite of the fact that it is possible to fail to demonstrate tubercle bacilli by laboratory examination, I think that tuberculosis in this patient may be pretty well ruled out.

Further cultures fail to reveal any fungus or other infectious diseases as a cause for these lesions. The case for sarcoidosis is not nearly as good as that for tuberculosis. It may be excluded on the basis of the lymph node biopsy.

We have no evidence of lesions in bone and there is no evidence of carcinoma elsewhere in the body metastasizing to the lungs. Hodgkin's disease is a possibility, but this is almost certainly ruled out by the lymph node biopsy. The lymphomas must be considered. However, there is no generalized lymphadenopathy, and certainly no cervical adenopathy evident in this patient.

Multiple myeloma is the disease which must be most seriously considered. Laboratory data supporting this diagnosis are the reversed albumin/globulin ratio, the plasma cells in the peripheral blood and bone marrow, and the Bence-Jones protein in the urine. This disease usually begins in later life. The symptoms are usually a type of girdle pain, but they can be localized. In this disease there are usually tumors in the ribs. Anemia is a very common finding. A plasma cell type of leukemia must also be considered here. Multiple myeloma has been present in several cases which have been diagnosed as myeloid leukemia. There is no support for the diagnosis of hypersplenism to explain this patient's symptoms. In my opinion this case belongs in the tumor group, and my diagnosis is multiple myeloma associated with plasma cell leukosis.

Dr. T. C. Laipply: The cloudiness which showed in the urine did not completely disappear when the urine was boiled. It increased again when the urine was cooled. Dr. Marquardt, do you think this is a typical reaction for Bence-Jones protein?

Dr. Marquardt: I think it is a characteristic reaction in that there was some clearing of the urine upon boiling even though the precipitate did not completely disappear. This is the reaction one would expect when Bence-Jones protein is mixed with albumin in the urine.

Dr. Laipply: Dr. Rhoads, what did you think of this case?

Dr. P. S. Rhoads: My first diagnosis is multiple myeloma. The other things which I think should be seriouly considered are sarcoidosis, tuberculosis, and an aleukemic leukemia.

Dr. Laipply: Does anyone think that fever is a constant finding in multiple myeloma?

Dr. David E. Markson: I had a case with a constant fever. The lesion in this case looks like a myeloma of some kind, but the lungs are rarely involved.

Dr. Laipply: Dr. Marquardt, would you like to tell us what is in the lungs?

Dr. Marquardt: The lesion in the lungs could be either tumor or congestion.

Dr. Laipply: Dr. Cannon, would you give us your opinion as to what is in the lungs?

Dr. Cannon: In my opinion this is an infiltrative lesion in the lungs.

Dr. Laipply: Dr. Isaacs, what is your diagnosis?

Dr. Bertha Isaacs: My first choice would be hypernephroma with metastases to the lungs, my second would be Hodgkin's disease, and my third diagnosis would be multiple myeloma.

Dr. F. H. Lestina: Was a blood calcium done on this patient?

Dr. Hilker: No. None was done. The blood phosphorous was 4.29 mg. per 100 cc.

Dr. Lestina: A blood calcium would help in the diagnosis on this patient. It should be elevated in multiple myeloma.

Dr. Laipply: Dr. Lestina, what is your diagnosis?

Dr. Lestina: My first diagnosis would be leukemia, and my second diagnosis would be multiple myeloma.

Dr. Laipply: Many metastatic tumors destroy bone, and in most cases of multiple myeloma there are osseous lesions. There are none in this case. Dr. Cannon, would you care to comment on this?

Dr. Cannon: What bothers us was that the infiltrative lesion developed so rapidly. We think it is uncommon for a neoplastic process to progress this rapidly. These lesions are uncommon for multiple myeloma and it is especially uncommon since there are no demonstrable bone lesions. I tend toward the diagnosis of an inflammatory lesion, perhaps tuberculosis in spite of the negative cultures.

Dr. Marquardt: I think that the lungs were wet. This represents an x-ray picture of wet lungs.

Dr. Laipply: What kind of heart disease does this patient have to account for the wet lungs?

Dr. Marquardt: I didn't say that the patient has heart disease. Perhaps this is on the basis of his anemia.

Dr. Patrick Riley: I would like to disagree with Dr. Marquardt about the lungs. The absence of engorgement of the pulmonary root vessels is definitely against edema. I think this is an infiltrative process, and the involvement of posterior portions of the lungs is highly suggestive of tuberculosis.

Dr. Laipply: Dr. Solovy, what is your diagnosis?

Dr. J. S. Solovy: My diagnosis is lymphosarcoma or multiple myeloma.

CLINICAL DIAGNOSIS

Miliary tuberculosis

DR. MARQUARDT'S DIAGNOSIS

Multiple myeloma associated with plasma cell leukosis

ANATOMICAL DIAGNOSIS

Plasma cell leukosis involving bone marrow, liver, spleen, kidneys, colon and lymph nodes

Hypertrophy and dilatation of heart (390 gm.)

Bronchopneumonia with abscess formation and organization, bilateral

Acute fibrino-serous pleuritis, bilateral

Acute glomerulonephritis

Acute leptomeningitis

Bacteremia (non-hemolytic streptococcus fecalis)

PATHOLOGICAL DISCUSSION

Dr. Laipply: As Dr. Marquardt has so accurately predicted, the major disease in this case is plasma cell leukosis involving bone marrow, liver, spleen, kidneys, colon and lymph nodes.

The heart was somewhat dilated, but not enough to cause cardiac failure. The acute glomerulonephritis was probably of not more than a few days' duration. This with the bacteremia with non-hemolytic streptococcus go together as part of an infectious process. The microscopic picture of the bone marrow at autopsy is much more characteristic than that seen during life. There are many immature cells resembling myeloid cells (Fig. 1). We must re-

(*Continued on page* 338)

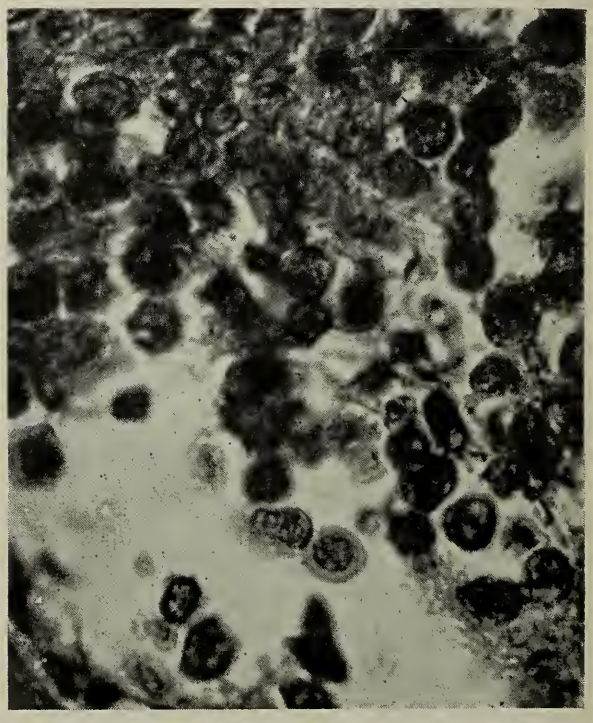


Figure 1. Plasma cell myeloma involving bone marrow.

EDITORIALS

DIABETES WEEK

November 15 through 21 will mark the sixth annual Diabetes Week inaugurated and sponsored by the American Diabetes Association. This event is almost unique among the national "Weeks" of various organizations dealing with special diseases. It is not a drive for public funds. It is a campaign of service, with the dual purposes of discovering unknown diabetics and educating both the public and the profession in the facts they should know about this disease. Implicit in these purposes is the conviction that early diagnosis and treatment minimize severity and prevent or delay complications.

With such aims physicians are bound to be sympathetic. The question is how best to achieve them. The American Diabetes Association, desirous of working through the local units of organized medicine, has persuaded hundreds of county medical societies throughout to establish committees on diabetes. Each year at this time some of these committees arrange for publicity via newspapers, radio and television utilizing material furnished by the Association; set up screening centers manned by professional and lay people and employing testing reagents supplied gratis by the national organization; secure the cooperation of the members of the county society in performing free urine tests in their offices during that week for anyone who wants them; and arrange for experts in diabetes to address scientific meetings.

This is a plan which the county societies of Illinois might well emulate. While it will not be possible in most places to put it into effect by mid-November of 1953, it is not too early to think about 1954. Moreover, there is no reason why activities of this kind need to be confined to the officially designed Diabetes Week. For example, the Illinois Department of Public Health operated this year a most successful exhibit at the State Fair in Springfield during which a great many visitors were subjected to screening urinalyses. The county fairs which are held throughout the state during the summer would seem to provide excellent opportunity for public education and case finding under properly organized local medical groups. The state Public Health Department exhibit will be available for showing at such fairs during the next two years.

There are several steps, short of an organized campaign, which the individual physician can take this month in order to find new cases and to further public understanding of the disease. He can test his own urine and that of his family and friends. He can offer to perform urinalyses free of charge during Diabetes Week and induce the community hospital to do likewise. He can look particularly for diabetes in persons who are most subject to it—relatives of diabetics, the obese, the middle aged and those suffering from acute illness and accidents.

Diabetes Week will be introduced by a nationwide publicity campaign. Many patients and potential patients will hear of it and will ask questions. Doctors should be prepared to answer them by refreshing their memories concerning the principal facts of the disorder.

Diabetes is due to an absolute or relative lack of insulin, usually of hereditary origin. Insulin deficiency results in defective utilization of carbohydrate chiefly, but also of protein and fat. The unused sugar piles up in the blood and is excreted in the urine, carrying out with it large quantities of water and salt. These physiologic abnormalities account for the symptoms of excessive urination and thirst, loss of weight, hunger, fatigue, itching, visual disturbances, pain in the extremities and slow healing of injuries. It must not be forgotten, however, that considerable glycosuria may be present for years without symptoms; hence the need to search for hidden cases.

Even though typical symptoms be present, the diagnosis cannot be made without laboratory aids. The urine should be tested for sugar two hours after an ordinary meal, not on arising, for tests performed at the latter time are often negative in mild diabetes. Positive urine tests must be followed by blood sugar determinations because not all melituria is diabetic. Specimens of blood, as of urine, should be taken two hours after a meal, not fasting. Values over 200 mg. per cent in venous blood by the Folin-Wu method of analysis, or over 150 mg. per cent by methods determining true glucose, indicate diabetes. Values somewhat below these levels are doubtful and should be checked with a glucose tolerance test. A blood sugar below 120 mg. per cent (90 mg. per cent for true glucose) two hours after eating excludes diabetes with a high degree of probability.

Early detection of diabetes can be a real service to the public only if screening tests are followed by an accurate diagnosis and adequate treatment. Herein lies the physician's fundamental responsibility.—H. T. R.

In keeping with Diabetes Detection Week, November 15-21, 1953, we have included the article "Screening for Diabetes" elsewhere in this issue of the Journal. The Department of Public Health is willing to set up a similar urine testing station at other county fairs provided the local medical societies sponsor and support the projects. We urge all county medical societies to make use of this opportunity.

CALL FOR HELP WHEN IT'S NEEDED

The consultation continues to be the best way to solve certain clinical problems. The ideas of the general practitioner and the specialist are pooled for the welfare of the patient and the satisfactory outcome serves to strengthen the relationship between the laity and the medical profession.

Thirty years ago there were fewer specialists than today. They lived in the larger medical centers and did not compete with the general practitioner. The majority were professors more interested in research and teaching than in their practice. Now a days there are certified specialists in private practice and in clinics in many of our smaller cities throughout Illinois.

When the relationship between the specialist and the general practitioner is good, the community benefits because their medical needs are best served. But when feelings of competition and rivalry exist the family physician may hesitate to call in a colleague on a difficult case. Such reluctance is sheer neglect because every physician needs help from time to time. We are dealing today with an educated laity; they are aware of the fact that there is a natural limit to ability and that two heads are better than one. By refusing assistance the patient suffers and so does the reputation of the physician and the entire medical profession.

How can we improve the relationship between the specialist and the general practitioner? First we must agree that it is a man's privilege to choose work for which he is best suited. Many medical students know by the end of the third year that they want to live and work in a smaller community as a general practitioner. They plan their courses with this in mind and may apply for an internship in hospitals where training in general practice exists. Other physicians enjoy all branches of medicine and consequently dislike specialization. A few do not have the money necessary to tide them over three or more years of residency, especially those who are married and have children. The specialist, on the other hand, limits himself because he believes that he cannot hope to know all about every medical subject. As a result he learns as much as possible about the subject that appeals to him. In this regard the difference between the two groups is one of point of view.

We all recognize that the general practitioner

is the backbone of American medicine and in many areas he is the sole guardian of health. But by the same token he should realize that specialization is not new and that consultations date as far back as medicine itself. The two groups still need each other to practice modern medicine. When a consultation is in order the family physician should summon the best qualified specialist in the community. He should be a man or woman well known in medical circles for his ability in the confronting situation. It is advisable for the physician to make available to the specialist all information including x-rays and laboratory data.

All too often the question of the specialist's conduct gives the family physician greatest concern. But this need not be a problem according to Graham[1] if the two get together and review ahead of time the simple rules of procedure dealing with the consulation. The fee should also be established if there is a question along this line. There will be no trouble if the consulant remembers that he has been called in to work through the physician in charge; he should not be guilty of usurping the stage and should remember from the beginning to the end that he is only a consultant.

It is preferable to see the patient together but to discuss the case elsewhere. When talking to the family the attitude of the consultant must be friendly but with sufficient dignity to show respect for the situation. Consultations are rarely forgotten by the family. It is best to discuss differences or major changes in therapy alone to avoid misunderstanding by the family. When finished the consultant should say a few words to those concerned that he is leaving the patient in capable hands.

Graham, Hervey King: Relationships in Consultation. California Med. 79: 240-243 (September) 1953.

HOUSE CALLS

Doctors Couter, Held and York[1] of Decatur discovered after making 1,000 house calls that one out of every four visits was unwarranted because the individuals were well enough to go to the office. Three hundred twenty-five of the visits were made between 7 a.m. and noon, 311 from noon to 6 p.m., 206 from 6 to 8 p.m., 111 from 8 p.m. to midnight, and 47 after midnight. Of the latter, 15 required a physician within four hours and 27 were symptomatic but could have been seen the following morning. One additional patient had to be seen within 12 hours. The remaining four patients did not need physical therapy nor emotional reassurance at that hour.

One hundred thirty-five different diseases were encountered during the 1,000 house calls; 14 of the conditions covered 66.4 per cent of the total calls. The most common clinical entities in order of frequency were influenza, follicular tonsillitis, nasopharyngitis, pneumonia, gastroenteritis, anxiety state, cardiac failure, bronchitis, acute back pain, urinary tract infection, coronary artery disease, cholecystitis, cerbrovascular accident, and bronchial asthma.

This study was undertaken to obtain statistical information on house calls. It demonstrates that there are many opportunities to do research in small communities. The results were interesting and practical. Most of the patients were over 65, "emphasizing the importance of geriatric medicine." It also disclosed the drugs most needed in the doctor's bag. The authors found that the following 16 products were used most frequently: aspirin compounds, penicillin with or without streptomycin, soporifics, barbiturates, meperidine (Demerol) hydrochloride, Triple Sulfas suspension (combination of sulfadiazine, sulfamerazine, sulfamethazine, and alcohol), cough syrup, morphine, aminophylline intravenously, meralluride (Mercuhydrin) sodium, sodium salicylate orally and parenterally, dihydroergotamine methanesulfonate (D.H.E. 45), dimenhydrinate (Dramamine) parenterally, Kaopectate, diphenhydramine (Benadryl) hydrochloride parenterally, and codeine orally.

Fourteen other drugs were included in the bag even though they were used occasionally. They were digitoxin orally and parenterally, camphorated opium tincture, amobarbital (Amytal) sodium parenterally, epinephrine (Adrenalin) in oil, atropine parenterally, quinidine orally, glucose intravenously, methantheline bromide (Banthine) parenterally, pentylenetetrazol (Metrazol), nitroglycerin (glyceryl trinitrate), procaine amide (Pronestyl) hydrochloride intravenously neostigmine (Prostigmin) parenterally, calcium gluconate parenterally, and methantheline bromide orally.

NEW INDUCTION POLICIES FOR SPECIAL REGISTRANTS

Changes in policies affecting physicians, dentists and veterinarians who are subject to the Doctor Draft Law announced today by Colonel Paul G. Armstrong, State Director of Selective Service for Illinois.

Colonel Armstrong said the local boards have been requested to discontinue processing Special Registrants for physical examination and induction due to the fact that the Armed Forces do not expect to levy calls for Special Registrants during the remainder of the present fiscal year. However, the local boards are continuing to classify Special Registrants.

Special procedures have been adopted in the case of doctors who are both special and regular registrants, a regular registrant being one who is subject to the Universal Military Training and Service Act and who may be liable for induction into the Armed Forces as a private. Colonel Armstrong said such registrants shall be processed for induction as regular registrants without regard to their priority status as doctors. These men will be given an opportunity to apply for commissions in reserve components of the Armed Forces, but they must do so prior to their induction date.

Colonel Armstrong stated that it is the policy of the Armed Forces to utilize in a commissioned rather than an enlisted status any Special Registrant who qualifies for a commission. Therefore, the induction of a regular registrant who is also a Special Registrant will be postponed if the man has either (a) applied for a reserve commission and has not failed to accept such a commission when tendered, or (b) accepted a commission in a reserve component of the Armed Forces or the Public Health Service prior to the date he is to report for induction.

Whenever such a registrant is in a class available for military service, or is placed in such a class by his local board, the local board will advise him by letter tht in order to be eligible for postponement of induction he must apply for a reserve commission within thirty days after the date of the letter. The local board will enclose forms for him to fill out and return immediately to the local board. He will then receive the necessary application forms from the Armed Force to which he has been allocated, and these also must be completed and returned at the earliest possible moment.

It is presumed, according to Colonel Armstrong, that registrants obtaining reserve commissions will be called to active duty as soon as their services can be utilized in a commissioned status. Such registrants will be inducted as enlisted men only if they fail to apply for, or to accept when tendered, a commission in a reserve component of the Armed Forces and if they do not hold commissions in the Public Health Service. If a regular registrant fails to accept a commission within thirty days after it is tendered, the military authorities will notify the State Director of Selective Service.

Physicians, dentists and veterinarians are reminded that when they are discharged from a reserve component of the Armed Forces, they must register with Selective Service immediately as they are liable under Special Registration.

Special Registrants are likewise reminded that any change in their status, including marriage, birth of children, completion of specialty training, acquiring state license, or passing specialty board examinations, must be reported to their local Selective Service board as required by law.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Avoidable Hospitalization

W. C. Bornemeier, M.D.
Chicago

Avoidable Hospitalization is a major factor in the high cost of medical care today. It does not seem to make much difference whether or not such inpatient service is covered by insurance. Many who have no insurance have a pocket full of money and like to be admitted to a hospital if any medical care is indicated. The people who have neither insurance nor money go to the hospital when medical care is indicated because it seems to have become one of man's inalienable rights and therefore should not be denied.

The people who have insurance covering hospital care have been educated by the advertising of the insurer to enter a hospital for every medical service.

If it were possible to popularize outpatient service to the extent that people would go to the hospital only when bed care is needed, a great annual saving should result. Everything possible should be done to make outpatient care attractive. First and foremost, all services must be available under one roof in attractive surroundings, under orderly supervision. People do not like to go all over town to get tests and consultations. Patient must be seen on regular schedule. Long waits, especially in crowed waiting rooms where there is no assurance that the stay will soon end, are terribly annoying. No wonder people prefer to go to the hospital where they can sit with their shoes off and enjoy the morning paper while waiting for the orderly to call for them and wheel them to the consultant. They can live a life of leisure while collections are made of their body secretions and excretions.

If it were possible to correct the impression that a patient can go into one door of a hospital and come out of another a few days later with a sure diagnosis of all of his ills, much of the problem would be solved. But not knowing where the wrong idea originates, the situation must be corrected by hard work.

One of the first things to do is to change the insurance so that a patient can be covered for diagnostic service. One of the results of this has been a challenge to the insured to get the service even if it is not included. Many times the active or passive cooperation of the physician has been needed. Whether or not the patient is the eventual winner, the services have already been performed as an inpatient.

It migt be cheaper for the insurance plan to give outpatient service, rather than pay for bed care while the patient pays for the diagnostic

service. However, many insurers consider ambulatory diagnostic service to be a non-insurable risk. They hold that something to be insurable should be unexpected and unavoidable. An elective annual examination, therefore, could not be insured against. Yet many sudden unexpected and unavoidable discomforts need a diagnostic work-up. The patient may recover completely during the procedure. The result is a hospitalization for diagnosis only, or so it may seem to one who reviews the record. The doctor who tries to convince the insurer that the patient needed to be hospitalized is sometimes viewed with a jaundiced eye.

In some places health care plans where complete medical, hospital, drug and dental care are given and paid for out of the same fund have solved the problem of Avoidable Hospitalization. These plans, being either competitive or limited at the source for funds do not permit hospitalization at the plan's expense if adequate service can be given as an outpatient. Various figures on the saving of hospital costs have been quoted, some as high as 50%. There may be objections to these plans, but certainly they have eliminated the cost of unnecessary hospital stay.

Group practice, the establishment of clinics where service for diagnosis and treatment plus consultation is readily and completely available, help to popularize outpatient service.

The office of the family doctor, where a complete history, physical examination and minor laboratory work are available will still suffice for most ills. Occasionally x-ray consultation will be need but this is easy to get as an outpatient. Consultation with other colleagues is seldom needed, but should be available at a reasonable fee.

Centers for diagnosis only have not worked out well because treatment has been divorced from the work-up, and check-up for treatment control is not readily available. Unneeded tests are done if groups of tests are sold as a package.

Prepaid group insurance seems to be a good solution to the problem of unnecessary hospitalization. This plan for administering medical care at the moment is not popular with the medical profession. We must remember, however, that progress in many fields of endeavor has sometimes been made in the direction of the unpopular. Certainly we must occasionally reevaluate our ideas and attitudes.

One of the chief reasons for the unpopularity in some medical circles of the prepaid group plans is the fact that Health Co-ops are being promoted by labor and the promotion often includes a tirade against organized medicine. Almost always the family doctor is referred to as a good fellow, but "medicine's official spokesmen" are blasted.

Any plan of medical care that (1) gives good service to the sick patient at a price that is as reasonable as possible and (2) pays the doctor adequately and (3) provides a favorable environment for both doctor and patient should be considered favorably. If such a plan succeeds in eliminating unneeded hospitalization, it will have accomplished much and will certainly have reduced the cost of medical care.

THE P.R. PAGE



Physicians' View of Press

Relations with the press are of supreme importance in the public relations of medicine, for the press is the principal channel of mass communication between profession and public.

Yet, in a recent survey of all branches of sciences, less than half the physicians replying to a questionnaire said they held a favorable opinion of press reports on medicine.

In contrast, the survey showed that 60% of all the scientists replying, including physicians, considered current science reporting as fair to adequate.

(Why do physicians go apart from other scientists in this regard? Are physicians harder to please? Is their field more difficult to cover than chemistry or atomic energy? Are they more sensitive because of their continuing battle to fight off socialization? Do their ethical restrictions make them more conscious of the quality of reporting in the medical field? Or is it that medicine, the scientific subject with the greatest popular appeal, is more intensively covered by the press?)

To a request for suggestions to improve science reporting, most of the physicians replied that copy should be checked back with the source for accuracy. Most also would ban "spectacular, romantic or emotional" presentations of medical news. Only one thought the reporters need to know more about medicine.

(Most experienced reporters rarely submit their copy to the news source for censorship. That is one point that may lead to conflict between press and profession, but a good reporter feels competent to report accurately news given him in intelligible form and he resents censorship automatically and aggressively.

(His experience also shows that comments on such releases often show lack of understanding of the problems of newswriting. And usually there is not enough time to permit him to check back his version of the interview. A physician interviewed may properly offer to check over a story, or even suggest it, but he should not insist on it. If he does not trust the reporter's ability and experience, he should make some remarks about the weather, and let it go at that.)

The results of the survey, which was conducted by Hillier Krieghbaum, associate professor of journalism at New York University, were published October 10 in Editor & Publisher, the J. A. M. A. of journalism.

* * *

Pamphlet Printing

The new pamphlet by the Committee on Medical Service and Public Relations outlining a county society P. R. program has passed the proof-reading stage and should be in the hands of county officers by the time they read this.

* * *

New A.M.A. Pamphlet

Meanwhile the A. M. A. has produced "Rx: P.

R.", a public relations manual of medical practice, a well-illustrated 68-page booklet in color on (a) how to handle patients, and (b) the business side.

* * *

More TV Opportunity

New TV stations, as they spring up here and there, offer unique opportunity to get medicine's story told.

Sangamon County, with a new station getting set to go in Springfield, is working out plans for regular programs, sparked by Dr. Jacob E. Reisch. They plan to do some radio work, too. Details later.

And Adams County, where Dr. Harold Swanberg is secretary of the public relations committee, is already at work. The society is co-operating with the Adams County Health Department to present a weekly TV program, "Your Health," over KHQA, a station in Hannibal, Missouri, which also serves the Quincy area. Some programs will be live telecasts, using Quincy Little Theater and Dramatic Club talent. Each Friday at 8:00 p.m., Channel 7.

An astonishing wealth of good material is available for such Radio and TV use, simplifying your task.

* * *

Ambulance Speed

The mayor of Decatur decided to check with the experts; so he asked the Macon County Medical Society how fast ambulances should be allowed to travel. Actually, the Society's Medical Service Committee found, there are really very few emergencies that call for great speed (with resultant risk to patient, doctor, and others) and the Society approved its recommendation that ambulances follow all speed and traffic regulations. So did the mayor. Seems sensible.

* * *

Bulletin Covers District

The Macon County Society, which has published its own lively bulletin for its own members for several years, has expanded its area of operations to take in the whole seventh council district. The bulletin is now mailed to all members in the district. This will certainly prove a service to the members of the many societies which are too small to support a bulletin of their own. A string of correspondents in the other counties will broaden reader interest. Rockford, Springfield, et al: Please note.

* * *

Chicago Auxiliary Plans

The Woman's Auxiliary to the Chicago Medical Society held its annual public relations luncheon November 17 in the Congress Hotel. Dr. Stanley P. Reimann, scientific director of the Institute for Cancer Research, Philadelphia, spoke on "Research Today" to a large audience of members and guests.

PATHOLOGY (Continued)

member that this autopsy examination was made 53 days after hospitalization, and long after the original bone marrow examination was done. It is not fair to say that the original examination was not correct, because in 53 days many changes can take place. In the bone marrow there are many mature plasma cells. The spleen is not unusual except for hemosiderin pigment, and infiltration with plasma cells.

This case differs from the usual one of multiple myeloma in that the bone marrow is diffusely and uniformly involved without nodule (myeloma) formation and cortical bone destruction. Plasma cell leukosis is considered an appropriate designation for a case of this type.

KNOW YOUR SOCIETY

COUNCIL COMMITTEES (Continued)

(1) Crippled Children's Clinic Committee. This Committee of the Council cooperates with the Division of Services for Crippled Children of the University of Illinois in its work throughout the state. Policies to be followed in the cooperation between the Division and the county medical societies, are worked out and reported to the Council for final approval. The activity of the committee depends upon the need existing at the time, and the chairman, who has served for several years, is well informed and very familiar with various situations throughout Illinois.

(2) Committee to Investigate Coroner's Office. This committee is comparatively new, but its work is extremely important and its activities intense and concentrated. For many years physicians and medical organizations have been aware of the inadequacies of the Coroner system in Illinois which has not been changed essentially since 1874. The importance of the more modern and more efficient Medical Examiner System for the scientific examination and investigation of deaths from unnatural causes has been considered by many groups. Any such change would necessitate a constitutional amendment which is a difficult procedure.

This committee worked to develop such an Act and to have it accepted by the Illinois legislature. In cooperation with our Committee is the Illinois Bar Association; other groups are not only interested, but vitally concerned. The final report of the legislative committee has not been made to the secretary's office, but the work in the field is progressing. The efforts of the committee will continue until such time as Illinois has laws comparable with those in states considered "model", and until the residents are protected in every way possible under the law. If and when such a point is reached, perhaps this committee will be able to continue to serve in an advisory capacity, and cooperate with the authorities to maintain high standards throughout the state.

(3) Committee on Diabetes. The Committee on Diabetes, also a comparatively new committee, meets to discuss the problems of how the doctors of Illinois can improve the treatment of diabetes throughout the state. The detection of undiagnosed cases, and the education of the physician to do a better job in caring for the diabetic are phases of the work being developed by this group.

The work of the Department of Public Health at the State Fair in Springfield brought commendation from the Committee. The Committee is interested in the work of the American Diabetes Association and its "diabetes detection drives". The education of the physician and

the public was stressed as one of the important phases of work in this field. The Committee would like to work with the program chairmen at the county society level and furnish speakers through the Scientific Service Committee, and also on Postgraduate Conference programs.

(4) The Educational Committee. In 1922 the House of Delegates of the Illinois State Medical Society passed a resolution introduced by Dr. Charles J. Whalen to the effect that it go on record as endorsing a broad plan of publicity through pamphlets, addresses and the lay press, to the end that the public be enlightened on the truths and principles contained in the development, progress and present status of medicine in order to counteract the propaganda of many sects who claimed superiority in methods of healing. At the September, 1922 meeting of the Council a committee was appointed consisting of Drs. Whalen, Ferguson and Chapman. No instructions were given to this group, nor were any funds placed at its disposal. It was to be known as the "Lay Educational Committee", and in general its objective was to make the doctor and the public better acquainted, and to present the physician to the public in a more favorable light. During the first year, money was collected by voluntary contributions, the average being $10.00 per number. The total collected was approximately $12,000.

In 1923 Mr. Jaklon was appointed as director of the work but remained only for a three months' trial period. In March, 1924 Miss Keller was employed as a full time secretary and a fourth man was added to the Committee personnel, which remained unchanged for the first decade of the Committee's existence. Two other lay secretaries have followed, Miss Jean McArthur, and Miss Ann Fox.

Since the end of the second year, the Committee expenses have been met by regular appropriations.

1926-1927	$14,381.53	About $1.75 per member
1929-1930	$11,751.00	About $1.60 per member
1935-1936	$ 8,721.05	About $1.30 per member
1941-1942	$13,574.97	About $1.65 per member
1945-1946	$11,169.47	About $1.26 per member
1950-1951	$20,729.48	About $2.10 per member
1951-1952	$21,531.51	About $2.21 per member

From its organization the Committee has regarded the county society as the sole judge of the Committee's activities in any county. The county societies have used, or failed to use, the various facilities of the Committee as they wished. Cooperating with various lay organizations has been one of the Committee's most important contributions to organized medicine.

Since early days the Committee has insisted that pre-school children examinations should be made by the family physician in private practice, and at a reasonable fee where the family is able to pay. This attitude and this work goes on today, supervised by a sub-committee of the Educational Committee itself.

Many of the annual reports of the Committee, published in the Handbook for the House of Delegates contain summaries of the work of the committee through the years. In the year ending May 1, 1933, 11,055 articles were released to newspapers; 1,156 articles concerning topics designated for Health Week were released. 112 popular health articles were written and approved by the Committee. 84 newspapers were sent special articles telling the story of National Institute of Health work. 561 radio talks were given over stations WAAF, WGN, WJJD and KWY.

In 1935 almost daily lectures were given at the Century Progress; the committee busied itself in combatting the campaign of the anti-vivisectionists; 14,592 newspaper releases were mailed out.

Certain principles were established early — to quote from a paper given in 1938 — "For the protection of the Committee and of the radio station itself, each speaker is requested to submit a copy of the paper he expects to read. This paper is censored by at least two members of the Committee. Subjects on which there is a material difference of opinion in the profession are not discussed. Treatment is not discussed except in most general terms. Speakers do not exploit themselves."

In July of 1936 the Committee began to use window exhibits at Marshall Fields. The manager of the building supplied the window space free of rental and service. The exhibits covered "Fourth of July Accidents, The Circulatory System, Cancer, Foot Disorders, Immunization, History of Surgery and Anesthesia, The Heart and Bronchosocopy."

In 1938 260 radio programs (the majority of

(*Continued on page* 348)

CORRESPONDENCE



AUXILIARY SALES IDEA FOR TODAY'S HEALTH

Today's Health has since it was first made an Auxiliary project by the American Medical Association been the "problem child" of the Auxiliary. Members have reluctantly accepted this chairmanship. It seems the time as come for a new approach. The magazine is good and can prove invaluable to lay people who have no other source of medical information than current women's magazines. Colliers and others; which in their efforts to be first in print with the advances in medical knowledge tend to be sensational, inaccurate or misleading.

True we have hounded the doctors to always have a copy of Today's Health in their reception room but where else would you find people more interested in their health than in a doctors office? It is to the advantage of the doctor and patient to have them read accurate informative articles rather than discuss their troubles and treatments with other patients.

Our aim is to get Today's Health into the hands of the public and it seems we have overlooked one of the best possibilities of accomplishing this by not taking advantage of the offer by the American Medical Association to use it, not only as a means of education but to swell the coffers of accepted charitable organizations. (these must be acceptable to your medical advisory committee) Cub Scouts, Boy and Girl Scouts are always anxious to augment their funds, also church groups, hospital auxiliaries, PTAs and other authorized organizations. Your auxiliary may determine the amount they wish to return to the charitable organization up to 50% of the subscription price.

Is there any better way to further public relations than the dissemination of authoritative information among lay organizations?

Mrs. Andrew J. Sullivan
Chairman, Today's Health

POST-GRADUATE TEACHING FUND FOR GIFT SUBSCRIPTIONS TO HOSPITALS

The International Academy of Proctology announces the establishment of a postgraduate teaching fund to provide gift subscriptions to the American Journal of Proctology to 750 of the largest Hospital Libraries in this country and abroad. Inasmuch as the American Journal of Proctology is the only offical Proctologic Journal in the world, these subscriptions will provide a continuing postgraduate course for interns, residents and hospital attending staff in all major hospitals.

As a teaching and educational organization, the Academy is pre-eminent in Proctology. The Annual Conventions are literally postgraduate courses, and the Journal has raised the level of Proctology throughout the world.

The International Academy of Proctology

recently announced the establishment of a Research Fellowship in Proctology with a grant of $1200.00 to the Jersey City Medical Center, Jersey City, New Jersey.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR DECEMBER

Sixteen clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will count 10 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The December clinics are:

December 2 — Hinsdale, Hinsdale Sanitarium

December 2 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Avenue

December 3 — Fairfield, Fairfield Memorial Hospital

December 8 — East St. Louis, Christian Welfare Hospital

December 8 — Peoria, St. Francis Hospital

December 9 — Elgin, Sherman Hospital

December 10 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

December 10 — Springfield, St. John's Hospital

December 11 — Chicago Heights (Rheumatic Fever), St. James Hospital

December 15 — Effingham (Rheumatic Fever), Douglas Township Building

December 15 — Peoria, St. Francis Hospital

December 16 — Chicago Heights, St. James Hospital

December 16 — Springfield (Cerebral Palsy), Memorial Hospital

December 17 — Bloomington, St. Joseph's Hospital

December 17 — Rockford, St. Anthony's Hospital

December 18 — Chicago Heights (Rheumatic Fever), St. James Hospital

PAN-AMERICAN ACADEMY OF GENERAL PRACTICE

Through the courtesy of the Government of Colombia, expressly, the University of Antioquia (celebrating their 150th year of its foundation) and the Dean of the Medical School, the Pan-American Academy of General Practice, has been invited to hold its annual Congress in the city of Medellin. Following Medellin, we will visit the cities of Bogota, Barranquilla and Montega Bay, Jamaica. The complete trip will be from February 15th to the 28th, 1954.

The Congress activities will be divided into sections, representing the various fields of Medicine, Surgery and Pharmacy. As a scientific event, it is of the highest importance, for it will offer Physicians of the United States an opportunity to cement their friendship with their colleagues of the Latin-American countries.

Those participating in this trip will be declared Guests of Honor, and there will be extensive festivities for our benefit. More than that it offers an opportunity for a delightful holiday in glamorous, exotic and historic Colombia.

Transportation at a special all inclusive rate, via, plane or steamship, will be available to those participating.

Registration must be made through — Dr. Arturo Martinez, Secretary, 500 West End Avenue, New York City

BOUGHT ANY NEW MEDICAL BOOKS LATELY?

Your older volumes would be gratefully received by the physicians, hospitals, and universities of Israel. Especially needed are books in the following categories:

All Medical Specialties, Anatomy, Aviation Medicine, Bacteriology, Biochemistry, Biology, Chemistry, Dentistry, Endocrinology, First Aid, General Practice, Gynecology and Obstetrics, Hospitals, Industrial Medicine, Internal Medicine, Medical Dictionaries, Mental Hygiene, Military and Naval Medicine, Nursing, Nutrition, Pathology, Personal Hygiene, Pharmacology, Physical Medicine, Physiology, Psychiatry, Psychology, Psychosomatic Medicine, Public Health, Surgery, Veterinary Medicine.

If you can spare any of these books, in good

condition and published since 1940, please send them by prepaid parcel post to : Books for Israel, 115 King Street, New York 1, N. Y.

AWARD FOR RESEARCH IN INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1954 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of one thousand dollars, and the essay will appear on the program of the 1954 meeting of the Society. Essays submitted in this competition must be received not later than March 1, 1954. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, Secretary, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

SCIENTIFIC PROGRAM OF THE SECTION ON CLINICAL CARDIOLOGY 1954

The Section on Clinical Cardiology of the American Heart Association will sponsor a two-day scientific program at the Conrad Hilton Hotel in Chicago on April 3 and 4, 1954. This program will constitute a portion of the Annual Meeting of the American Heart Association and immediately precedes the Annual Sessions of the American College of Physicians. The meeting will be open to all members of the medical profession. Doctor Wright R. Adams of Chicago is Chairman of the Program Committee. Members of the American Heart Association who wish to present papers should send a 250-300 word abstract of the proposed paper to Doctor Charles D. Marple, Medical Director, American Heart Association, Inc., 44 East 23rd Street, New York 10, New York. *All papers should be on subjects of distinct clinical interest. The deadline for the receipt of abstracts is January 1, 1954.*

INTERNATIONAL ACADEMY OF PROCTOLOGY AWARD

The International Academy of Proctology announces the establishment and award of a one year Proctologic Research Fellowship in the amount of $1200.00. This Research Fellowship grant has been awarded to the Jersey City Medical Center, New Jersey, to be administered under the direction of Dr. Earl J, Halligan, Surgical Director of the Medical Center.

Dr. Halligan is a former International President of the Academy. The Board of Trustees of the International Academy of Proctology will vote another Fellowship grant of a similar amount at the time of the next Annual Meeting of the Academy. Thus, there will be at least two Research Fellowship studies in progress, in different institutions, under the auspices of the International Academy of Proctology.

ILLINOIS SOCIETY OF ANESTHESIOLOGISTS

Tuesday, December 1, 1953
Passavant Memorial Hospital
303 E. Superior, Chicago
Scientific Program, 7:30 p.m., Room 108

"Anesthesia for Endoscopy in Children" — Dr. Paul H. Holinger, Professor of Bronchoesophagology, University of Illinois College of Medicine. Attending Bronchoesophagologist, Children's Memorial and St. Luke's Hospitals, Chicago.

Discussants:

Dr. Bryce K. Ozanne, Moline, Ill.

Dr. J. Earl Remlinger Jr., Secretary of the American Society of Anesthesiologists.

Business Meeting

Members of the Medical Profession are invited to attend the Scientific Meeting.

Herman Nebel, M.D., President
Bernard Stodsky, M.D., Secretary
H. Livingstone. M. D.
Chairman, Program Committee

NEWS OF THE STATE



CLINTON

Society News.—The Clinton County Medical Society was addressed at St. Joseph's Hospital, Breese, September 9, by Dr. W. S. Thimcen, East St. Louis, on "The Feeding and Care of Infants." On October 14, the Society was addressed by Dr. Harold K. Roberts, St. Louis, on "The Management, Care, and Diet of Diabetic Patients."

COOK

Good Scholastic Record Essential for Admission to Medical School.—Contrary to popular belief, a student does not have to boast a straight A average to gain admission to medical school. Nevertheless, a good scholastic record still is essential in order to gain one of 166 places available in the first-year class at the University of Illinois College of Medicine, it was recently reported.

Almost all students admitted to the class of 1957 have averages of 4.0 (B) for three or more years of pre-medical instruction. And, without exception, all are well above the minimum scholastic qualification of 3.5, as established by the Board of Trustees.

One student, Lyle Wacaser of Lovington, presented a straight A average for his undergraduate instruction. He attained this scholastic record at the Urbana-Champaign campus of the University of Illinois.

Though applicants are required only to have three years of college credit, 58 members of the new class already have earned degrees.

The Committee on Admissions selected the new class from 424 applicants who met all minimum requirements. Actually, a total of 506 applications were completed and filed. These totals are comparable to a year ago when 440 of the 564 applicants met all minimum requirements.

Five students have been admitted this year under the provisions of a program which is sponsored jointly by the Illinois Agricultural Association and the Illinois State Medical Society. This program is designed to enroll more students from rural areas in medical schools, and to return them to their native areas to practice.

All members of the new class are residents of Illinois. Half of those selected reside in Cook County, with the remainder from downstate areas, in ratio with the population of the state. The Committee on Admissions deemed it inadvisable to accept non-resident students because of the large number of qualified applicants from Illinois. This policy has been in effect since the close of World War II, although by ruling of the Board of Trustees, the Committee on Admissions is permitted to accept 10 per cent non-residents.

Factors in the selection of first-year students, in addition to scholarship, are the results of a professional aptitude test supervised by the Association of American Medical Colleges, recommendations from science teachers and pre-medical counselors, ratings on interviews with one or more members of the faculty, and a physical examination.

Four students who were enrolled at other medical schools were accepted with advanced standing. They will be members of the class of 1955.

Personal.—Dr. Ralph E. Dolkart participated in a course on "Recent Advances in Cardiac Therapy," in Charleston, W. Va., September 16.

Medical Education Funds to Illinois.—The National Fund for Medical Education has given $30,142.50 to the University of Illinois College of Medicine. Of this total, $1,882.50 represented gifts desig-

nated for the university by individual physicians. According to Dr. Roger A. Harvey, acting dean of the medical school, this fund was to be used for teaching purposes and only when regular budgets cannot meet the need. Thus, he pointed out, it helps the College of Medicine meet competition for staff in the middle of the year when budgets are fixed. "It enables the College to add staff for new programs while waiting for legislative mechanisms to recognize the need; and recently it has helped the College to extend its clinical teaching program to the four quarter system in spite of an over-all budget reduction."

Cancer Lectures.—On October 7, the fourth annual lecture series on cancer opened at Northwestern University Medical School, to run once a week for seven weeks. The series is covering brain, eye, pancreas, thyroid and pigmented skin tumors, diagnosis of breast cancer, enzymes and cancer, and radiation in treatment of tumors. Those participating are Dr. James W. Kernohan, head of section of pathologic anatomy and neuropathology, Mayo Clinic, "Brain Tumors"; Dr. A. B. Reese, professor of ophthalmology, College of Physicians and Surgeons, Columbia University, "Ocular Neoplasms"; Dr. Jesse P. Greenstein, chief of laboratory of biochemistry, National Institutes of Health, "Enzyme Levels in the Tumor-Bearing Host"; Dr. Otto Saphir, clinical professor of pathology, University of Illinois College of Medicine, "Pathologic Diagnosis of Breast Cancer"; Dr. Richard B. Cattell, Lahey Clinic, "Carcinoma of the Pancreato-Duodenal Area"; Dr. Austin Brues, director of biological and medical research, Argonne National Laboratory, "Radiation in Tumor Growth"; Dr. Warren Cole, professor of surgery, University of Illinois College of Medicine, "Carcinoma of the Thyroid Gland"; Dr. Arthur C. Allen, associate pathologist, Memorial Center for Cancer and Allied Diseases, "The Clinicopathologic Correlation of Nevi and Malignant Melanomas".

Dr. Sanford Named Head of the Department.—Dr. Heyworth N. Sanford, who has been serving as acting head of the department of pediatrics at the University of Illinois College of Medicine since September, 1952, has been appointed head of the department. He will also hold the title of professor of pediatrics. The appointment fills the vacancy created when Dr. Henry G. Poncher resigned last year to enter private practice. Dr. Sanford has been a member of the faculty of the University of Illinois since 1941 when he was appointed clinical associate professor of pediatrics. He was appointed to full professor in 1944. According to the Office of Public Information at the University, Dr. Sanford has resigned as chairman of the department of pediatrics at Presbyterian Hospital and as president of the medical staff. He will continue his association with Cook County Hospital.

Health Education Lecture Series.—An annual fall lecture series, presented by the Museum of Science and Industry, opened September 27, with a talk by Helen Ross, administrative director at the Institute for Psychoanalysis on "Personality Traits." Others in the series were: Dr. Herbert Rattner, professor and chairman, department of dermatology, Northwestern University Medical School, "Skin Blemishes and Their Treatment", October 4; Dr. Clifford J. Barborka, associate professor of medicine, Northwestern University Medical School, "Reducing Can Be Fun", October 11; Dr. Roland P. Mackay, professor of neurology, University of Illinois College of Medicine, "The Successful Marriage", October 18; Dr. Morris Fishbein, editor, World Medical Association Bulletin, professional lecturer in medicine, University of Illinois College of Medicine, "How Old Are You?", October 25.

James Campbell Returns to Chicago.—Dr. James A. Campbell, recently appointed director of the medical service at Presbyterian Hospital in Chicago, has rejoined the faculty of the University of Illinois College of Medicine with the rank of professor of medicine. Dr. Campbell returned to Chicago this past summer from Albany, N. Y., where he served for two years as dean and professor of medicine at Albany Medical College of Union University. Dr. Campbell previously served as associate attending physician at Presbyterian Hospital, and held the rank of assistant professor of medicine at Illinois.

Joint Diabetic and Heart Meeting.—At a joint meeting of the Chicago Diabetes and the Chicago Heart associations, at the Institute of Medicine of Chicago, October 6, Dr. Edwin F. Hirsch, pathologist at St. Luke's Hospital, spoke on "Studies of Diabetic and Other Hyperlipemias" and Dr. Jeremiah Stamler, department of cardiovascular research, Michael Reese Hospital, spoke on "Endocrine Influences on Lipid Metabolism" and "Atherosclerosis".

Formal Opening of New Students' Residence.—The first residence hall for students enrolled in medicine and the allied health sciences was formally opened on Sunday, September 27, in the Medical Center District on Chicago's near West Side. The University of Illinois Student Residence Hall, located at 818 S. Wolcott Ave., can accommodate a maximum of 405 students. Private financing has been employed by the University to construct and equip the $2,450,000, nine-floor building.

Though constructed primarily for University of Illinois students in medicine, dentistry, pharmacy, nursing, and occupational therapy, the residence hall also will accommodate undergraduates from three other professional schools located nearby. They are Chicago Medical School, Stritch School of Medicine of Loyola University, and Loyola University School of Dentistry.

Rooms also will be rented on a per diem basis to official visitors of the University, if vacancies occur.

There are 196 double rooms and 13 single rooms in the building. Each floor is equipped with a central washroom and a shower room. Special facilities include a laundry room, which is equipped with automatic washers and dryers.

Food service facilities which include a cafeteria, dining rooms, kitchen, and snack bar are located on the first floor. A large lounge on the second floor has been furnished with sofas and chairs, writing desks, and a 27-inch television set.

The Student Residence Hall has been under construction since May, 1952. T-shaped in design, it is of steel frame with concrete floor construction. It is faced with stone and brick. It was designed by Naess and Murphy, architects, under the direction of University of Illinois architects. James McHugh Construction Company, Chicago, was the general contractor.

The building is the fourth new facility to be opened in the rapidly-expanding, 305-acre Medical Center District this year. Previously placed into operation were the University of Illinois Staff Apartment Building, Kidston House—a staff apartment building at Presbyterian Hospital, and the 500-bed Veterans Administration Hospital.

PEORIA

Society News.—Dr. J. Arthur Myers, professor of medicine, University of Wisconsin, Madison, addressed a meeting at the Peoria Municipal Tuberculosis Sanitarium, on "Tuberculosis Eradication," September 22. Members of the Peoria Medical Society were in attendance.

ROCK ISLAND

District Meeting.—On November 18, the Iowa-Illinois Central District Medical Association will be addressed by Dr. Warren Furey, clinical professor of radiology, Stritch School of Medicine of Loyola University, on "X-Ray Diagnosis in the Acute Abdomen." The group was addressed September 23, by Dr. William E. Adams, professor of surgery, University of Chicago School of Medicine, on "Significance of Hemoptysis in Pulmonary Disease."

Personal.—Dr. Norbert C. Barwasser, Moline, attended the German Dermatological Society meeting in Frankfurt, Germany, in September, where he discussed a paper on "Antibiotics in Dermatology", which was presented by Dr. Joseph Klauder of the University of Pennsylvania, Philadelphia.—Dr. David A. Goldsmith, Rock Island, has been appointed city physician. A graduate of Northwestern University Medical School, Dr. Goldsmith has been practicing in Rock Island since January 1952.

SANGAMON

Fifty Year Member.—Dr. Clara Edmunds Holmberg was honored at the September 3 meeting of the Sangamon County Medical Society, when she was presented with a Fifty Year Club certificate and pin from the Illinois State Medical Society. Dr. Jacob E. Reisch, Springfield, Councilor of the fifth district of the State Medical Society, made the presentation.

Society News.—"Income Taxes" was discussed by William Van Meter, C.P.A., before the Sangamon County Medical Society, October 1. "Estate Planning" was discussed by Attorney Nelson O. Howarth.

WILL-GRUNDY

Interprofessional Banquet.—The second annual interprofessional banquet of physicians, dentists, and druggists, was held September 9, at the VFW Hall in Joliet. Dr. Oliver Beahrs, of the department of surgery, Mayo Clinic, Rochester, spoke on "Radical Surgical Treatment of Carcinoma of the Mouth and Neck." Following the scientific presentation, Dr. Beahrs provided entertainment with a sleight-of-hands demonstration which he has carried on as a hobby since undergraduate days.

WINNEBAGO

Society News.—A feature of the meeting of the Winnebago County Medical Society in Rockford, October 30, was a talk by Agent Lewis, of the Bureau of Narcotics, titled "Get the Dope."

Personal.—Dr. Hugh A. Johnson announces the opening of his office in the Gas-Electric Building, Rockford. He plans to limit his practice to plastic and reconstructive surgery.

GENERAL

Governor's Conference on Exceptional Children.—The tenth Governor's Conference on Exceptional Children opened at the Palmer House, September 25, with the theme "The Handicapped Child in the Mainstream." The keynote address was given by Miss Anna Engel who, for many years, was divisional director, department of special education in the Detroit public schools. In her talk, "Our Goal Is Integration", Miss Engel pointed out that while "special services in schools, recreation centers or institutions are essential for handicapped children, it is important to channel activities for these young people back into the mainstream of childhood experience wherever possible." Group meetings were devoted to the handicapped child in the regular school program; the community and the child in the institution; the handicapped child in the community recreation program; the preschool handicapped child; generic casework and the handicapped child.

First Meeting of County Health Boards.—A two day meeting of county and multiple-county boards of health opened in Springfield, September 24, the first of its kind in Illinois. The meeting was attended by officers and members of the state's

county boards of health representing twenty-seven counties: Adams, Alexander-Pulaski, Cook, DeWitt-Piatt, DuPage, Egyptian (Gallatin, Saline and White counties), Fulton, Jackson, JoDaviess, Lawrence-Wabash, Lee, McLean, Montgomery, Morgan, Peoria, Quadri-County (Hardin, Johnson, Massac and Pope counties, Shelby-Effingham, and Will.

Annual Health Report Available.—The thirty-fifth report of the Illinois State Department of Public Health for the year ended June 30, 1952 has recently been made available. The report covers the activities of the various divisions making up the State Health Department and includes statistical information on the communicable diseases reported in Illinois for the designated period.

Your Doctor Speaks over **FM Station WFJL.**—Since the last issue of the Illinois Medical Journal, the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks" over FM Station WFJL:

Ernest A. Rappaport, assistant professor of psychiatry, Chicago Medical School, October 1, What You Should Know About Psychiatry.

Eugene J. Ranke, assistant professor of medicine, University of Illinois College of Medicine, October 8, The Thyroid in Health and Disease.

Meyer Solomon, formerly assistant professor of nervous and mental diseases, Northwestern University Medical School, October 15, The Feeling of Inadequacy.

Your Doctor Speaks is presented through the **Educational Committee** of the **Illinois State Medical Society** in cooperation with **FM Station WFJL.**

Lectures Arranged Through the Educational Committee of the **Illinois State Medical Society:**

Eugene L. Slotkowski, Mothers' Club of St. Helen School, September 28, on Pointers on Good Health for Your Child.

Morris T. Friedell, Young Married Couples Sunday Evening Club in Austin Methodist Church, October 4, on Atomic Medicine.

Lawrence Breslow, Oakton PTA, October 19, on Helping Our Children Improve in Mental and Physical Health.

Alexander N. Ruggie, Fun-At-Maturity Group in the Sherman Park Library, October 20, on Arthritis: When Your Joints Ache.

Frank E. Doyle, Women's Council of Max Strauss Center, October 27, on From Menstruation to Menopause.

Leo Kaplan, Couples' Club of the Congregational Church of DeKalb in DeKalb, November 1, on Psychosomatic Medicine.

George V. Byfield, State Department of Health of Illinois Federation of Women's Clubs in Chicago, November 5, on A Physical Examination Once A Year.

Groves B. Smith, Godfrey, Okawville Woman's Club in Okawville, November 12, on Mental Health is a Community Problem.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Armand J. Mauzey, Elmhurst, Kane County Medical Society at Tally-Ho Inn near St. Charles, October 14, on Office Gynecology.

Norman L. Baker, Springfield, Marion County Medical Society at St. Mary's Hospital, Centralia, October 15, on Common Skin Tumors.

George Vlasis, Chicago, Rock Island Chapter of the Illinois Academy of General Practice in Moline, October 27, on Office Gynecology.

James H. Hutton, Chicago, Stock Yards Branch of Chicago Medical Society in Evangelical Hospital in Chicago, November 19, on Male Climacteric.

Abraham F. Lash, Chicago, Whiteside-Lee County Medical Societies at Nachusa Hotel, Dixon, November 19, on Treatment of Threatened and Habitual Abortions.

Norman Tobias, St. Louis, Montgomery-Macoupin County Medical Societies at St. Francis Hospital, Litchfield, December 15, on Office Treatment of Common Skin Diseases.

Harold C. Voris, Chicago, Whiteside-Lee County Medical Societies at Jul's Danish Farm, Sterling, December 17, on Clinical Recognition of Brain Tumors.

DEATHS

COLUMBUS BROWN, Herrin, who graduated at Missouri Medical College, St. Louis, in 1898, died September 5, aged 84, in Herrin Hospital.

FREDERICK WILLARD BROWN, Dwight, who graduated at Chicago College of Medicine and Surgery in 1911, died in Veterans Administration Hospital, July 12, aged 71.

ARTHUR N. CLAGETT, Evanston, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died September 20, aged 82.

FRANCES H. COOK, Chicago, who graduated at Bennett Medical College, Chicago, in 1911, died September 29, aged 80.

WINFIELD SCOTT DIXON, Metropolis, who graduated at Kentucky School of Medicine, Louisville, in 1893, died May 23, aged 83.

GEORGE DOHRMANN, SR., who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died September 25, aged 76. He was a past president of the surgical staff of Grant Hospital and a member of the "Fifty Year Club" of the Illinois State Medical Society.

CHARLES M. FOX, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1913, died September 23, aged 73.

HAROLD L. FRAZIER, Chicago, who graduated at Rush Medical College in 1901, died October 3, aged 75. He was a member of the staff of the Swedish Covenant Hospital.

WILLIAM RAY GOODRICH, Bluford, who graduated at the Chicago College of Medicine and Surgery in 1906, died July 15, aged 73, of coronary occlusion.

HENRY SAMUEL GUTERMAN, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1941, died August 6, aged 37, of polycystic kidneys. He was director in the department of research in human reproduction at Michael Reese Hospital.

GRANT HOUSTON, Joliet, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1894, died September 24, aged 89.

REZIN P. JOHNSON, retired, Chicago, formerly of Jacksonville, who graduated at Chattanooga Medical College in 1897, died September 18, aged 81.

JOHN KLEIN, retired, Chicago, who graduated at Rush Medical College in 1899, died September 14, aged 83.

MICHAEL LEWIN LEWINSKI, Chicago, who graduated at University of Lemberg, Austria, in 1917, died May 16, aged 63.

JOSEPH J. LINK, Mattoon, who graduated at Northwestern University Medical School in 1920, died recently, aged 58.

CHARLES NEWBERGER, Chicago, who graduated at Rush Medical College in 1909, died September 25, aged 69. He was emeritus assistant professor of obstetrics and gynecology at the University of Illinois College of Medicine and consultant in maternity, Division of Maternal and Child Hygiene, Illinois State Department of Public Health.

TROY SMITH, Chicago, who graduated at Indiana University School of Medicine in 1917, died September 21, aged 62.

ANTHONY SODARO, Chicago, who graduated at Loyola University School of Medicine in 1916, died September 24, aged 69. He was a member of the staffs of Oak Park, Mother Cabrini and St. Anne's Hospitals.

WILLIAM WILSON, Chicago, who graduated at Loyola University School of Medicine in 1916, died October 3, aged 63, in West Suburban Hospital where he was a member of the staff.

KNOW YOUR SOCIETY (Continued)

them in dialogue form) were given over Chicago stations. Radio scripts were furnished to Danville, East St. Louis, Decatur, and Bloomington.

In 1953 the Committee had been on the air for 3½ years with its own Television program over WGN-TV. Other television work included cooperation with the program "All About Baby" over WNBQ. Five persons were scheduled to appear on "They Stand Accused", also over WGN-TV network.

Radio work included the series "Your Doctor Speaks" now in its fourth year over the FM station WFJL.

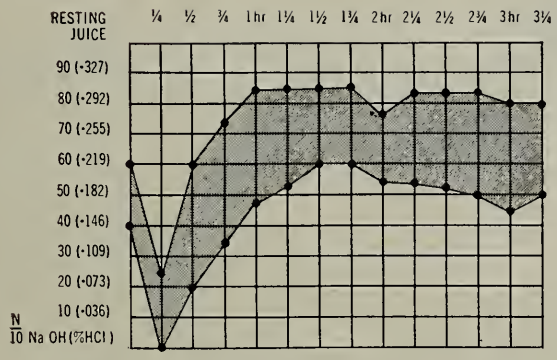
The speakers' Bureau scheduled 103 speakers before various organizations throughout the state. The weekly mailing list for HEALTH TALK was well over a thousand.

While some of the public relations work, originally assigned to this committee, naturally has been absorbed by the Public Relations Counsel of the State Society, the work with lay groups is fundamentally public relations in practice, and the influence of the Committee through the years has been used to "present the physician to the public in a more favorable light".

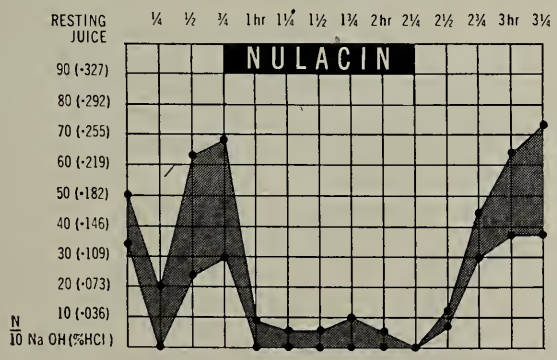
The services of the Committee, thirty years old this year, are still at the disposal of county medical societies and lay groups throughout the state.

(Portions of this summary were taken from material prepared by Dr. James H. Hutton for a paper presented before the Secretaries' Conference in 1938)

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In active ulcer flare-ups, two to three tablets per hour, starting one-half to one hour after each meal, are prescribed. During quiescent periods, the suggested dosage is two tablets between meals.

Indicated in active and quiescent peptic ulcer, gastritis, gastric hyperacidity. Available through all pharmacies in tubes of 25 tablets.

1. Douthwaite, A. H., and Shaw, A. B.: The Control of Gastric Acidity, Brit. M. J. 2:180 (July 26) 1952.

2. Douthwaite, A. H.: Medical Treatment of Peptic Ulcer, M. Press 227:195 (Feb. 27) 1952.

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BOOK REVIEWS



PEDIATRICS. L. Emmett Holt, Jr., and Rustin McIntosh. 12th Edition, 1953. 1542 pages. $15.00. Appleton-Century-Crofts, New York.

For the past half century—and more—any medical student has come to feel that "Holt" and "Pediatrics" were practically synonymous. There had been, of course, many earlier works on the subject. Your reviewer has a ponderous four volume Diseases of Children edited and compiled by John M. Keating and published in 1889 which still makes delightful reading if one has enough time. But, when it comes to honesty of thought and conciseness of presentation, Holt's Pediatrics, beginning with the first edition published in 1896 and through all subsequent editions is second to none.

The latest edition, the twelfth, ably carries on the Holt tradition. There are 72 collaborating authors, most of them from the East, and all of them well qualified to present their subjects. The entire range of Pediatrics is covered; the latest diagnostic methods, therapeutic developments and preventive measures are all thoroughly and yet concisely presented.

This is essentially a book for the medical student but will prove invaluable to the busy practitioner. Illustrations and charts are not too numerous but are excellently reproduced. There is an Appendix which must be studied to be appreciated, as it contains data on growth and development not usually made so easily available. The contents are arranged in a logical manner and there is an excellent index.

The book itself, although heavy is well-bound and lies flat when opened. The type is easily read; the text is set in a single column to the page. The various subdivisions of each chapter have short bibliographies which facilitate reference finding. The various authors are conspicuous by their modesty, acknowledgmen' being only by initials at the end of their contributions.

This book is recommended as a valuable addition to the professional library of any doctor.

J. C. McK.

THE SURGERY OF INFANCY AND CHILDHOOD, ITS PRINCIPLES AND TECHNIQUES. By Robert E. Gross, M.D., D.Sc., 1000 pages. 1488 Illustrations on 567 Figures. W. B. Saunders Company, Philadelphia and London, 1953. Price $16.00.

This beautiful and remarkable book is indeed an epoch-making addition to surgical and Pediatric literature. Its accomplishment is a lasting monument not only to the author, but to the cooperation afforded him by the cooperation of the Harvard Medical School and the untiring staff work of the Boston Children's Hospital.

Pediatric Surgery is in many ways different from that done on Adults and yet it is not Dr. Gross' opinion that it should be split off as a separate specialty. Rather, he recommends that surgeons, particularly those who are especially interested in these little patients make serious effort to study the peculiar problems involved. "Vitality necessary is a special knowledge of the pathology which will be encountered and a familiarity with the best methods of correcting the condition which is found." He believes also, and his results would appear to substantiate his belief, that the responsibility for surgical pediatric cases should rest entirely with the surgical service. Hence, this book deals with the pediatric surgical case as a complete diagnostic, preparatory, surgical and post-surgical task and for this reason it should have a wide acceptance in the profession. For those connected with large institutions it will tell when surgery should be con-

(*Continued on page* 60)



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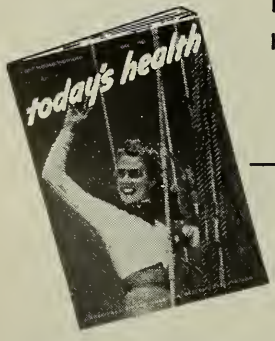
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BOOK REVIEWS (Continued)

sidered and what may be expected from that service. For those in smaller centers it will give the internist valuable information as to how he may best cooperate with the surgeon and will give the surgeon knowledge as to the best surgical procedures.

Yet this is not a book of surgical technique. Etiology, symptoms and signs, differential diagnosis, treatment and pathology are considered in every condition. A great need for a text on surgical diagnosis is being met, which should result in a great improvement in surgical judgment for most of us. The entire field of general surgery is covered; neurosurgical, orthopedic and otolaryngological are considered to be specialties and are not considered. It is difficult to pick any section as outstanding unless it be that on cardiac surgery. The entire book is exceptional.

There are numerous, well reproduced illustrations including very clear roentgenograms. The book is well-bound and lies flat when open. It is hoped that this book will not find itself limited to the surgeons' libraries as no doctor who sees infants and children should deny himself and his patients the help which it can give.

J. C. McK.

PSYCHIATRIC DICTIONARY. By Leland Hinsie, M.D., and Jacob Shatsky, Ph.D. Second Edition. Oxford University Press, 1953. Price $15.00.

Some nine hundred terms have been added in a Supplement to this Dictionary which was first published in 1940. The same method is followed in both the Supplement and the Original Dictionary, which together make a reference volume of nearly 800 pages. A short definition is given, followed by a more elaborate description with clinical illustrations and, in many cases, with quotations from authorities in psychiatry, to whose books references are made in connection with the more important or controversial concepts.

With one exception, a different group of collaborators have helped with Supplement and Original Dictionary, but the entire volume has been well integrated through the professional knowledge of the authors, both in psychiatry and library research.

F. G. N.

DICTIONARY AND PSYCHIATRY AND PSYCHOLOGY by William H. Kupper, M.D. and Douglas M. Kelley, M.D. The Colt Press, 1953. Price $4.50.

Much information has been packed into less than 200 pages of this little handbook. Not only are there brief dictionary definitions of many terms, but also brief biographies of important psychiatrists and psychologists as well as extended, almost textbook-like discussions, of many subjects of importance in both fields.

The book is well bound with smooth, substantial paper, increasing the value for frequent references. The brief treatment of important terms will prove unsatisfactory for leisurely study and research, but the

(*Continued on page 62*)

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OPHTHALMIC OINTMENT

BOOK REVIEWS (Continued)

condensations of important information will prove a boon to the student or the busy practitioner.

F. G. N.

NOMENCLATURE AND CRITERIA FOR THE DIAGNOSIS OF THE DISEASES OF THE HEART AND BLOOD VESSELS. A new Fifth Edition, the first since 1939, is a completely revised and greatly expanded monograph, published by the New York Heart Association and distributed by the American Heart Association and its affiliates.

This monograph is intended primarily to clarify and standardize diagnostic criteria for cardiovascular diseases, but it contains in concise form a veritable mine of information on the subject. It has been the standard work for the use of cardiologists, internists, general practitioners, medical students, interns and residents from its first appearance in 1929. All editions have been prepared by the Criteria Committee of the New York Heart Association under the chairmanship of Dr. Harold E. B. Pardee. For the first time, the new edition contains a section on the diseases of the peripheral circulation. There have been extensive revisions and additions to the sections on electrocardiography, radiology, and the diagnosis of congenital heart disease and rheumatic heart disease. A new table of functional and therapeutic classification appears.

This monograph contains 360 pages, is profusely illustrated, and is bound in cloth. The price is $4.95. It may be ordered through your local heart association, or directly from the American Heart Association. It is also available through many medical bookstores.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ANATOMY AND SURGERY OF HERNIA: Leo M. Zimmerman, M.D., Professor of Surgery and Co-Chairman of the Department of Surgery, Chicago Medical School; Attending Surgeon, Michael Reese, Cook County and Chicago Memorial Hospitals, and Barry J. Anson, Ph.D., Med. Sc., Professor of Anatomy, Northwestern University Medical School; Member of Attending Staff, Passavant Memorial

(*Continued on page* 64)



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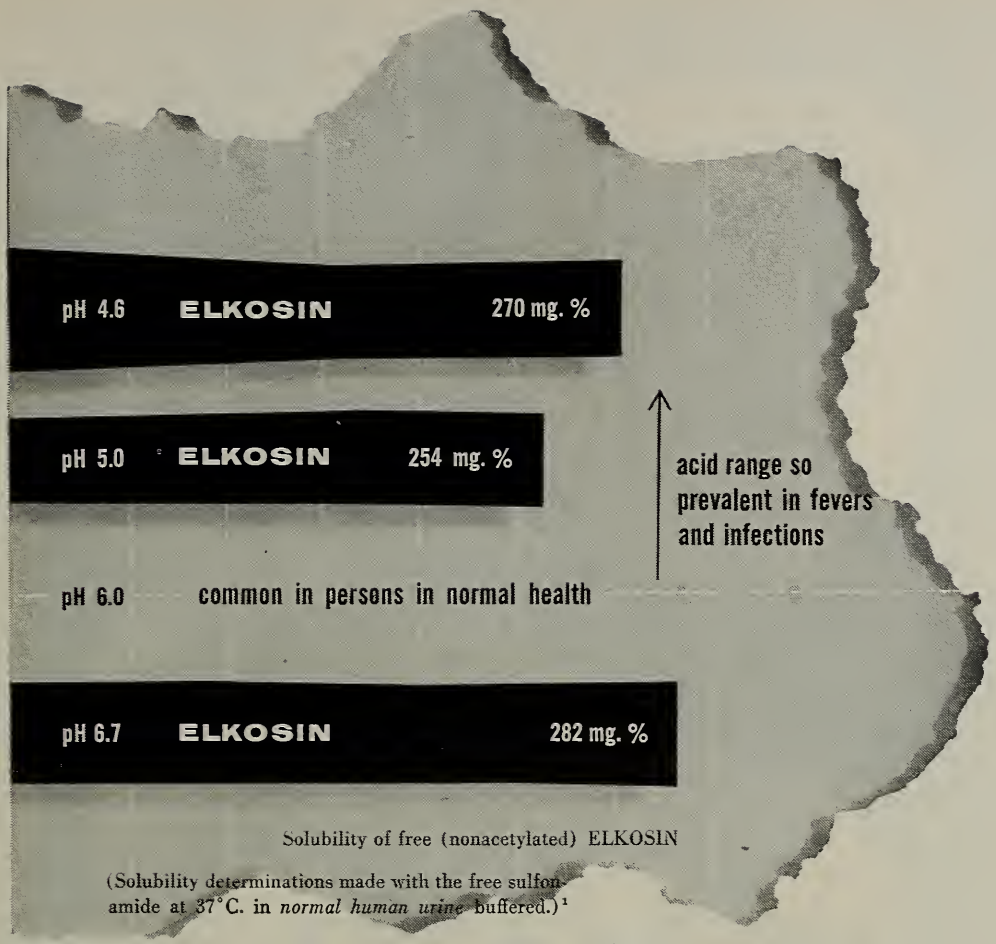
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1. Ziegler, J. B.; Bagdon, R. E., and Shabica, A. C.: To be published.

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BOOKS RECEIVED (Continued)

Hospital, Chicago; The Williams and Wilkins Company, Baltimore, 1953. Price $10.00.

SURGICAL TECHNIQUE and Principles of Operative Surgery: By A. V. Partipilo, M.D., F.A.C.S., Associate Clinical Professor of Surgery, Stritch School of Medicine of Loyola University; Senior Attending Surgeon, Columbus Hospital; Foreword by Alton Oschsner, M.D., F.A.C.S., William Henderson, Professor and Director of the Department of Surgery, The Tulane University School of Medicine, New Orleans. Original Illustrations by W. C. Shepard and Hooker Goodwin. Fifth Edition, Thoroughly Revised. With 548 Figures Containing 998 Illustrations. Lea and Febiger. Philadelphia 1953. Price $15.00.

THE RADIOLOGY OF BONES AND JOINTS: An Introduction to the Study of Tumours and other Diseases of Bone. By James F. Brailsford, M.D., Ph.D., F.R.C.P., Hunterian Professor, Royal College of Surgeons, England. Fifth Edition With Over 725 Illustrations. The Williams and Wilkins Company. Baltimore 1953. Price $19.00.

MANAGING YOUR CORONARY: By William A. Brams, M.D. Illustrations by Hertha Furth. J. B. Lippincott Company, Philadelphia and New York. Price $2.95.

WATER, ELECTROLYTE AND ACID-BASE BALANCE — Normal and Pathologic Physiology as a Basis for Therapy. Harry F. Weisberg, M.D., Assistant Professor of Clinical Pathology and of Clinical Medicine, The Chicago Medical School; Clinical Chemist, Mount Sinai Medical Research Foundation and Hospital; Associate Attending Physician, Cook County and Mount Sinai Hospitals; Chicago, Illinois. The Williams & Wilkins Company, Baltimore, 1953. Price $5.00.

SYMPTOMS OF VISCERAL DISEASE — A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine. Francis Marion Pottenger, A.M., M.D., LL.D., M.A.C.P., Medical Director, Pottenger Sanatorium and Clinic for Diseases of the Chest, Monrovia, California; Professor Emeritus of Clinical Medicine, University of Southern California; Author of "Clinical Tuberculosis," "Tuberculin in Diagnosis and Treatment," "Muscle Spasm and Degeneration," etc. Seventh Edition. With 87 text illustrations and 10 color plates. The C. V. Mosby Company, St. Louis, 1953. Price $7.50.

BAILEY'S TEXT-BOOK OF HISTOLOGY. Revised by Philip E. Smith, Ph.D., Sc.D., Professor Emeritus of Anatomy, College of Physicians and Surgeons, Columbia University and Wilfred M. Copenhaver,

(*Continued on page* 66)

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Ph.D., Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Thirteenth Edition. The Williams & Wilkins Company, Baltimore, 1953. Price $9.00.

THE NURSING MOTHER — A Guide to Successful Breast Feeding. Frank Howard Richardson, M.D., Licentiate American Board of Pediatrics, F.A.C.P., F.A.A.P., Prentice-Hall, Inc., New York, Price $2.95.

THE ROCKEFELLER FOUNDATION — Annual Report, 1952. 49 West 49th Street, New York.

DISABILITY EVALUATION — Principles of Treatment of Compensable Injuries. Earl D. McBridge, B.S., M.D., F.A.C.S., Assistant Professor in Orthopedic Surgery, University of Oklahoma, School of Medicine; Attending Orthopedic Surgeon to St. Anthony's Hospital; Associate Orthopedic Surgeon to Wesley Hospital; Visiting Surgeon to W. J. Bryan School for Crippled Children; Chief of Staff to Bone and Joint Hospital, Oklahoma City, Oklahoma. 376 figure numbers. Fifth Edition. J. B. Lippincott Company, Philadelphia, London, Montreal. Price $15.00.

PSYCHOTIC AND NEUROTIC ILLNESSES IN TWINS. Medical Research Council Special Report Series, No. 278. By Eliot Slater, with the assistance of James Shields. Statistical Appendix by Joan May. London: Her Majesty's Stationery Office, 1953. Price $4.75.

THE HEBREW MEDICAL JOURNAL. Semi-Annual Publication. Moses Einhorn, M.D., Editor, Volume 2, 1952. 25th Anniversary Year. 983 Park Avenue, New York 28, New York.

CLINICAL ENDOCRINOLOGY. By Lewis M. Hurxthal, M.D., F.A.C.P., Head of the Department of Internal Medicine, Lahey Clinic, Boston; Physician, New England Baptist and New England Deaconess Hospitals, Boston, and Natalija Musulin, B.S., M.D., staff of Cooper Hospital, Camden, N. J. Two volumes. 482 figures, 146 charts, 1 color plate. J. B. Lippincott Company, Philadelphia, London, Montreal. $24.00.

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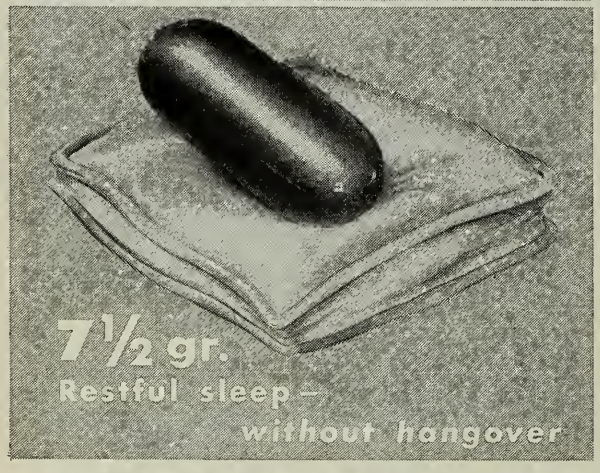
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DON'T TALK!

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be constructed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticize destructively and unethically but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient. *Louis J. Regan, M.D., Malpractice And The Physician. Wisconsin M.J., Jan. 1953.*

Used Car Salesman (demonstrating car): "You don't often get a chance to buy a car like this. I tell you it's a real opportunity."

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Minimal tuberculosis . . . is a potentially serious disease. It is ultimately capable of leading to advanced disease in one of four, prolonged chronic illness in one of ten, and death in one of twenty. Its behavior under modified bed rest treatment can be demonstrated to be affected principally by the amount of tuberculosis present at the outset, and how long it has been there unpredictable behavior remains the predominant feature of minimal tuberculosis. Roger S. Mitchell, M.D., Am. Rev. Tuberc., April, 1953.

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Don't eliminate a food from a patient's diet for longer than three or four weeks unless the asthma is better when the food is avoided and worse when it is eaten. All traces of food suspected by history or skin test should be excluded for three or four weeks. The success of elimination diets depends largely upon the thoroughness with which the patient is told how to avoid suspect foods in disguised form.

Don't fail to prescribe a balanced diet from permitted foods if the elimination diet is to last longer than two or three weeks.

Don't assume that a positive skin test indicates clinical sensitivity to the reacting antigen. The patient must improve when avoiding and get worse when in contact with it and/or he must be improved by injections to it.

Don't think of skin tests and asthma diagnostic studies as synonymous.

Don't start allergen injection until food and inhalent avoidance and treatment of any infection present have failed to control asthma. *Oscar Swineford, Jr., M.D., "Don't Do This For Asthma. South. Med. & Surg., July 1935.*

The decline in the annual number of new cases of tuberculosis reported during recent years has been slight compared with the decline in mortality. That the number of newly reported cases remains high, despite the rapid decline in death rates, underscores the fact that efforts to wipe out tuberculosis must continue to have high priority among public health problems. Division of Chronic Disease and Tuberculosis, Public Health Service, Public Health Reports, June, 1953.

More emphasis is needed on health education which should be taking its rightful place with older public health technics in our programs, and a greater willingness is needed for wide participation by the health officer in community affairs, not just as an official but as an individual with special contributions to make in many fields. Berwyn F. Mattison, M.D., American J. of Pub. Health, December, 1952.



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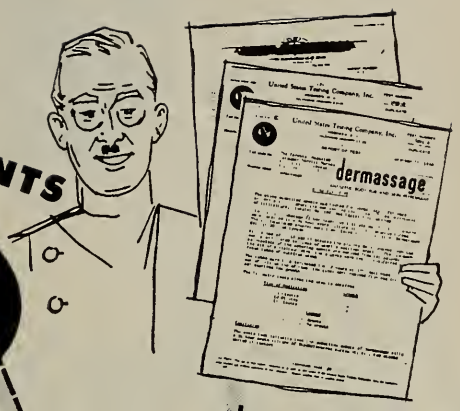
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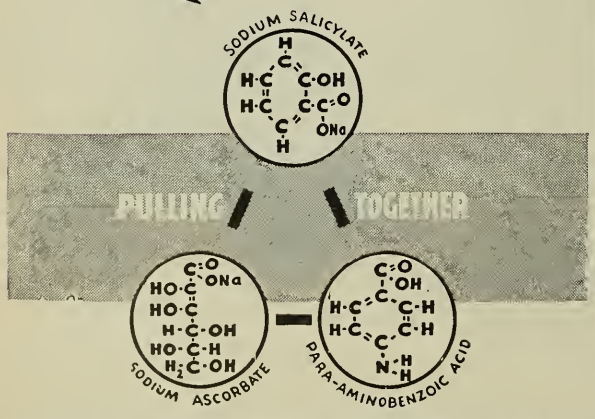
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BRONCHO MONILIASIS

Certain mycotic infections of the lungs have long been recognized as entities. Blastomycosis and actinomycosis are the most common examples. Monilia, on the other hand, is comparatively less pathogenic to man and often leads a tenacious saprophitic existence in human tissue. However, given a primary lesion in the lung with probable biochemical tissue changes affording a favorable medium for its unrestrained growth, coupled with the inherent or acquired susceptibility of the host. the fungus may become distinctly pathogenic in the lung and produce a chronic suppurative inflammation known clinically as broncho-moniliasis (or more recently called candidaisis). *R. J. Antos, M.D., Broncho-Moniliasis. Arizona Med., March 1953.*

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MALPRACTICE AND CASE HISTORY

The importance of good medical case records, as a factor in malpractice prophylaxis, cannot be overestimated. A good medical case record should contain a history of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as a basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter a good record will reflect (by means of progress notes), a sequential history of the case, its course, complications, and sequelae and thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case also are part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course. *Louis J. Regan, M.D., Malpractice And The Physician. Wisconsin M. J., Jan. 1953.*

"How did you get your prize bird-dog back? Last time I saw you you thought he had been stolen."

"Well, I thought and thought about it and then I put an ad in the paper saying: Lost or ran away, liver-spotted setter name Bill. Will probably show signs of hydrophobia in about three days . . . and, do you know, that dog came back the next morning!"

The mild, inapparent infection of early adolescent years may be the origin of the destructive tuberculosis of puberty or adulthood. Rene J. Dubos, M.D., The American Review of TB, July, 1953.

Routine chest X-ray examination provides a unique opportunity for the accurate detection of early intrathoracic disease, and that the nodules which are discovered in supposedly normal people may represent significant lesions, particularly bronchogenic carcinomas. Sidney E. Wolpaw, M.D., Annals of Internal Medicine, September, 1952.

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SCHIZOPHRENIC WRITINGS

In examining a set of writings of 75 delinquent persons, it was startling to observe that many characteristics found in the schizophrenic writings were found in those of delinquents as well. The chief characteristics in the delinquents' writings were the abrupt stop above the line, the covering stroke, the leftward tending half oval, the small tight loops, breaks, and mends. The only outstanding difference between the writings of the delinquents and the schizophrenics was the use or nonuse of the "flier" and the abrupt stop above the line. This suggests that we consider why one person should be a schizophrenic and another a delinquent. Evidently the abrupt stop above the line in connection with the other formations, especially those indicating aggression, must mean that the patient has turned away from the self and projected the conflict on to the environment, while the other individual with the "flier" (lack of reality principle), plus the other formations which the delinquents evidence, instead of outward manifestations, retreats within the self and becomes schizophrenic. *Anita M. Muhl, M.D., Evaluation of Schizophrenic Writings. J. Am. M. Woman's A., Jan. 1953.*

Look to your health; and if you have it, praise God, and value it next to a good conscience, for health is the second blessing that we mortals are capable of—a blessing that money cannot buy. Izaak Walton, Think, May, 1953.

The charming young bride was presented an imposing package with an accompanying note: "My dear; wear this on your wedding night, and you will be sure to wow him."

With visions of treasures, came the night, the eager bride unwrapped the beribboned package. The box was empty.

The following advertisement appeared in a physical culture magazine: "Here's a good test for your midsection muscles. Clasp hands overhead and place feet together on floor. Now bend to right at waist as you sit down to the left of your feet. Then, by sheer force of your muscles, haul yourself up, bend to left and sit down on floor to right of your feet. Stick with it and let us know the results."

The next day a letter came in. It said simply: "Hernia!"

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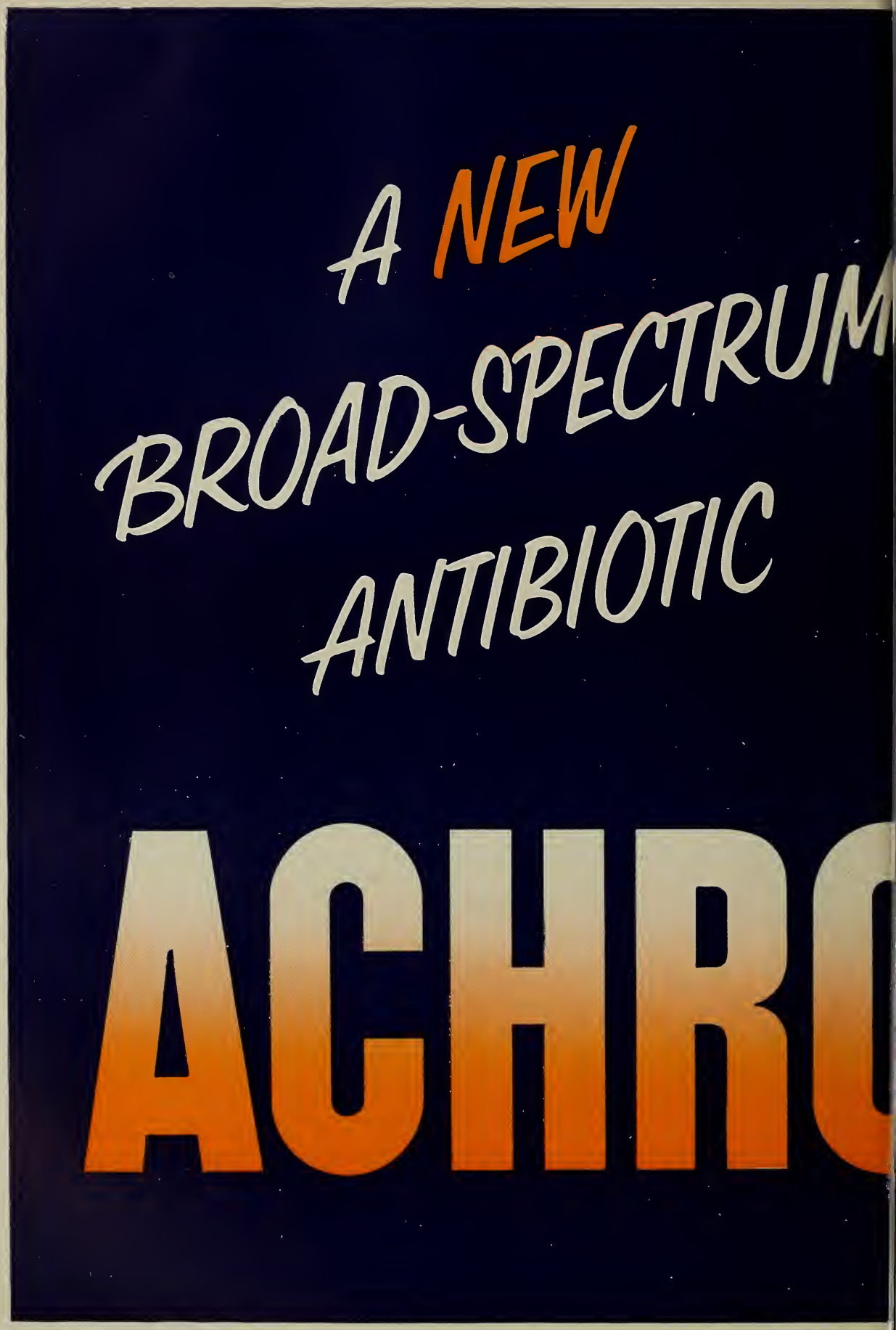
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Official Journal of the Illinois State Medical Society

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Vol. 104, No. 6 December, 1953

The Social and Economic Impact on Medicine of the Control of Infectious Diseases

Perrin H. Long, M.D.
New York City

In these times, and as far as one can judge in the future, the maintenance and the promotion of the health of the people of these United States has, and will continue to be, a matter of continuing national interest. In no other country is so much newspaper space allotted to matters dealing with health (and also the ills) of our people. Organizations such as the American Cancer Society, the Infantile Paralysis Foundation, the American Heart Association, and about a score of other groups, are receiving and disbursing annually many millions of dollars of the public's money for specific health purposes. Charitable foundations such as Rockefeller, Ford, Carnegie, Markle, Commonwealth, Macy and others have made, and will continue to make, large financial contributions for the support of various phases of medical education and research. Federal, state, and municipal governments are contributing billions of dollars to the support of medical care and research. There can be little doubting that the Health Sciences have become in the American parlance "Big Business". It is time to analyze briefly, what has been accomplished, what may be accomplished, and what problems currently have been created, or may arise, as a result of advancing knowledge in the Health Sciences. A one-sided effort in this field, not co-ordinated with current or developing social, economic and political forces could produce dire results.

In the historical yearnings of all people, and hence in their mythologies, there has always been a "Golden Age", a period in which the people were free from want, free from fear, and free from illness. Unfortunately, as far as historical records are concerned, there is little evidence that the "Golden Age" was ever more than a myth. The estimates of the average lengths of lives which are included in Table 1 show quite definitely that from the dawn of historical times until about a hundred years ago, man's allotted time on this earth was fleeting. It is recognized that most of the figures included in Table 1 represent calculated guesses, because the data on which they are based are scanty, but they are probably not too far wrong.

There is ample evidence derived from Roman and Greek ruins in the Mediterranean area that

Executive Officer and Professor, Department of Medicine, College of Medicine, State University of New York at New York City.

Oration in Medicine presented before the General Assembly, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 21, 1953.

Certain phases of the work presented in this report were supported by a grant from the Lederle Laboratories Division, The American Cyanamid Company.

TABLE 1
AVERAGE LENGTH OF LIFE FROM ANCIENT TO MODERN TIMES*

SOURCE	AGE IN YEARS
Iron and Bronze Age. Greece, Angel.	18
2000 Years Ago. Rome, Pearson.	22
Middle Ages. England, Russell.	33
1687-91. Breslau, Halley.	33.5
Before 1789. Mass. and N. H., Wigglesworth.	35.5
1838-54. England and Wales, Farr.	40.9
1900-02. U. S., Glover.	49.2
1950. U. S., Dublin.	68.2

*Figures taken from LENGTH OF LIFE. Dublin, L. I., Lotka, A. J., and Spiegelman, M., The Ronald Press Co., New York, Revised Edition, P. 42, 1949.

the ancients possessed some understanding of the importance of providing pure water and of the disposal of sewage, if large urban areas were to exist. However, there were essentially no advances in this type of knowledge, and even a loss, or disregard of it, in the centuries which intervened between the rise and fall of the Greek and Roman civilizations and the development of the Industrial Revolution in England, which followed the design of effective steam engines by Watt, beginning in 1763.

By the early part of the nineteenth century, the era of industrialization was well under way and with it came the problems of overcrowding and poverty in the industrial areas, large families, child labor, and long hours of work under unsatisfactory conditions, all of which factors worked to produce conditions favorable for the spread of epidemic disease. This combination of factors was also responsible for the awakening humanitarian and scientific, as well as purely economic interests in the problem of what could be done to relieve the lot and improved the health of the inhabitants of these industrial communities.

The health situation in many industrial areas was execrable by the middle of the nineteenth century. In Table 2 are listed the changing death statistics in the State of Massachusetts for the past one hundred years. If one looks back a hundred years ago, one finds that the annual mortality rate was nearly double what it is now, and that tuberculosis, infant deaths, pneumonia, scarlet fever and typhoid fever were taking a heavy toll of lives. The same was true of that time in every city in Western Europe and this country. But, as has been pointed out previously, social reform was under way, and in the health field, Edwin Chadwick in England and Lemuel Shattuck in this country were laboring

TABLE 2
CHANGES IN MORTALITY FROM CERTAIN CAUSES OF DEATH DURING THE PAST CENTURY; MASSACHUSETTS FROM 1856-1865 TO 1952

Cause of Death	Death Rates Per 100,000 Living People				
	1856-65	1900	1916	1936*	1951
All Causes	1,794.7[1]	1,823.5	1,492.9	1,173.5	1,117.5
Typhoid and Paratyphoid	92.5	22.5	4.6	.3	.04
Diphtheria	86.1	45.9	16.8	.6	.2
Measles	17.1	11.8	10.4	.8	.1
Scarlet Fever	101.3	13.9	3.4	1.0	—
Whooping Cough	23.8	12.0	9.2	1.2	.1
Small Pox	11.0	—	—	—	—
Tuberculosis (All Forms)	446.4	253.6	145.2	43.3	18.9
Pneumonia (All Forms)	107.4	188.3	106.3	45.3	26.8
Infant Mortality	174.0[2]	156.7	99.8	46.6	21.9

1. Death rate for 1856-60.
2. Rate for City of Boston 1849-50 per 1,000 live births.
*Year sulfonamides were introduced into the U.S.

to develop communal interest and responsibility for disease control. Initial efforts were directed towards the development of methods for recording births, deaths and diseases, the provision of pure water, food and milk, the proper disposal of sewage and wastes, and the lessening of overcrowding. These initial goals were based upon observations of supposed cause and effect, and could be achieved at least in part by empirical methods.

In any understanding of what has happened in Western Europe and North America in relation to health within the lifetimes of our grandfathers, fathers and ourselves, careful attention must be given to the general awakening of the human mind which followed the Renaissance. Political, social, philosophical and scientific thinking were newly oriented, and while they did not, and are not proceeding apace, still extensive developments in all areas of thought have had their influence on the health of our people. It is therefore not surprising that while the first steps in the public health movement were based on empiricism, at the same time the medical sciences, especially that of bacteriology, were on the march.

To be realistic, one must give the major credit, as far as the remarkable progress which has been made in promoting longevity and increasing and maintaining certain aspects of health, to the scientists, clinicians and public health workers in the field of infectious diseases and processes. If one checks tables which deal with rates of occurrence of disease, and of causes of death from disease, one can find that the major improvement in health which have been recorded in the last hundred years are the result of the control of infections by prophylactic procedures, and the treatment of injections by sero- or chemotherapeutic and antibiotics agents. Actually, if one compares the advances in the medical sciences as outlined in Table 3, with the decreases in the mortality rates from major infections diseases, as recorded in Massachusetts in the last hundred years, the noteworthy facts are the very definite declines in deaths from major infectious diseases, with the exception of pneumonia, which were recorded by the year 1900. It is fair to say that decreases in the mortality rates were primarily due to the control of infectious diseases by public health methods, improved environmental conditions, and to the wane of certain pandemic diseases in the instance of diphtheria and scarlet fever. In 1900, specific therapy for most infec-

TABLE 3
SANITARY AND MEDICAL CONTRIBUTIONS TO LONGEVITY

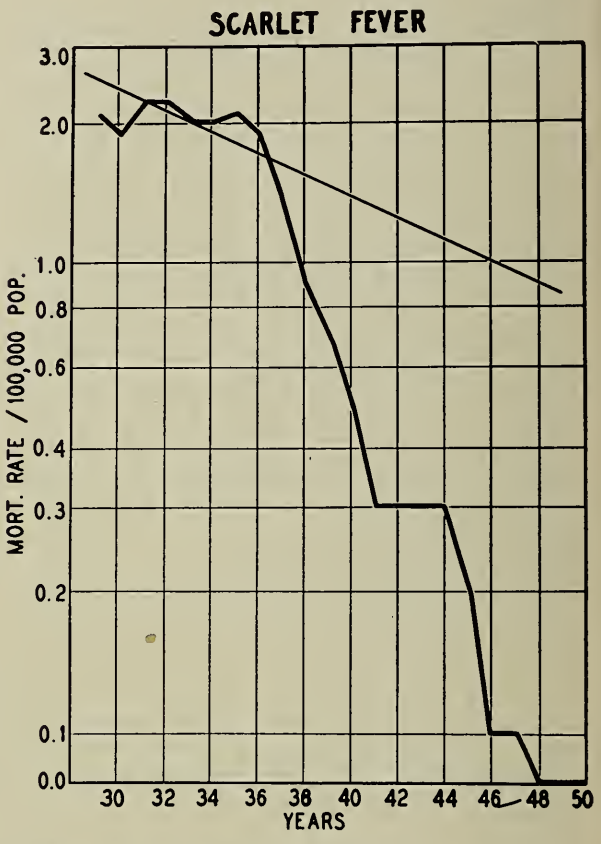
APPROXIMATE YEAR	CONTRIBUTIONS
1798	Jenner. Vaccination against smallpox.
1840	Snow. Pure water supplies.
1840	Wells, Morton and Long. Anesthesia.
1854	Pasteurization of milk.
1860	Lester and Halsted. Antisepsis and asepsis in surgery.
1869	Massachusetts Department of Public Health.
1870	Closed systems of sewage.
1875	Pasteur and Koch. Science of microbiology.
1890	Antitoxin. Von Behring and Kitasato.
1894	Typhoid vaccine. A. E. Wright.
1895	Roentgen ray. Roentgen.
1897	Vitamins. Eijkmann.
1897	Mosquito borne diseases. Ross.
1898	Radio-therapy. Curie.
1907	Transfusions. Crile, Jansky, Moss.
1908	Chlorination of water. Johnson in Chicago.
1910	Chemotherapy. Ehrilich.
1915	Hormones. Thyroxin. Kendall.
1923	Toxoid. Ramon.
1933	Sulfonamides. Domagk.
1938	Antibiotics. Dubos.
1929 :40	Penicillin. Fleming, Florey.

tious diseases was known. Vaccination against smallpox, which was the responsibility of both the individual physician and of public health physicians, was the major way in which the physician as an individual worker (as opposed to group action by practicing physicians in public health matters) participated in the mass improvement of health in the community.

Between 1900 and 1936 (the latter year marks the indroduction of the sulfonamides in this country) mortality rates fell appreciably as is shown in Table II. Again in most instances, credit must be given to public health procedures, better environmental conditions, and to the wane in the epidemicity of certain diseases. However, in the prevention or treatment of certain infectious diseases the individual physician was coming into his own. Diphtheria antitoxin decreased the number of deaths from diphtheria. Immunizations against typhoid fever, diphtheria and whooping cough reduced the incidence of these diseases. How much, is a matter of dispute and is another question! The development of the arsenicals for the treatment of syphilis eventually lowered the death rate in that disease. Scarlet fever-antitoxin, and especially potent anti-pneumococcal sera played a definite part in preventing deaths from scarlet fever and pneumococcal pneumonia. The combined impact of the advances in the diagnosis and therapy of illnesses as outlined in Table 3, was important in the general improvement of certain aspects of the health of our people. If a digression is allowable, a study of the figures in Table 2 relative to deaths from tuberculosis is very revealing. If the currently accepted figure, that for every death recorded from tuberculosis there are minimally ten patients ill with this disease, is projected back a hundred years ago, (one can estimate that at that time this ratio was much higher than ten to one), it becomes clear that there was hardly a family in Massachusetts in which at least one member was not suffering from "consumption"!

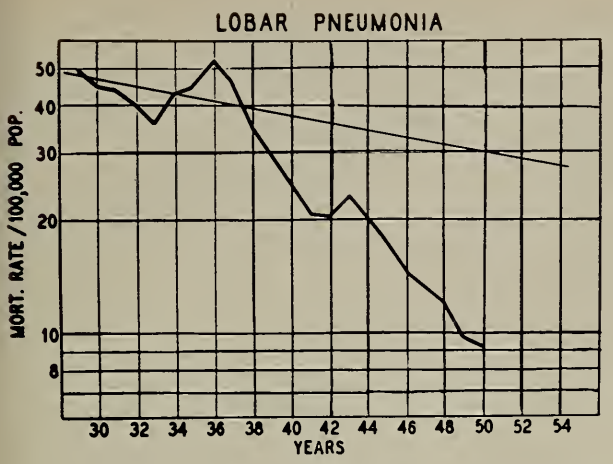
In December, 1933, Domagk in Germany performed the crucial experiment which proved the value of the azo- compound subsequently called Prontosil in the treatment of Beta hemolytic streptococcal infections. Little, however, was heard about this drug, or its active ingredient, sulfanilamide, until late in 1936 or early in 1937. In fact, as far as the impact of sulfonamides on preventing deaths is concerned, notable effects on the mortality rate in the United States (and these were in hemolytic streptococcal infections) were not noted until the year 1938.

The chart depicting what has happened since that time relative to scarlet fever (and to hemolytic streptococcal infections) is interesting. It is to be noted that the mortality rate dropped sharply until 1940, then it leveled off for three



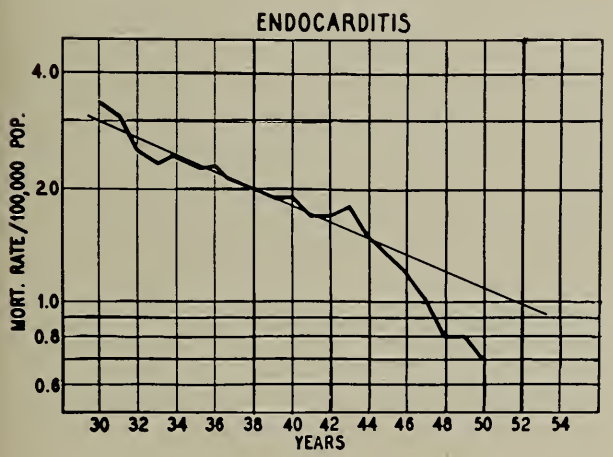
years, and after the introduction of penicillin, it dropped sharply again. By 1948 an official mortality rate of zero was registered for this disease. (N.B. Mortality statistics in the United States are carried out to two decimal points.)

The mortality rate from lobar pneumonia had been declining for a number of years prior to the introduction of sulfonamides, due to the increasingly wide-spread, therapeutic use of potent, type-specific anti-pneumococcal sera for treating pneumococcal pneumonia. As can be seen from the trend line in this chart, this decline was gradual and predictable in a fair degree. The introduction of sulfapyridine, and subsequently of sulfathiazole and the sulfadiazines, and then the antibiotics, brought about a sharp reduction in the mortality from lobar pneumonia. It must be said that while further reductions in deaths



from lobar pneumonia can be expected, the mortality curve in this disease will probably taper off very gradually, because many deaths from pneumonia are occuring despite the use of antibiotics, in greatly debilitated, elderly people.

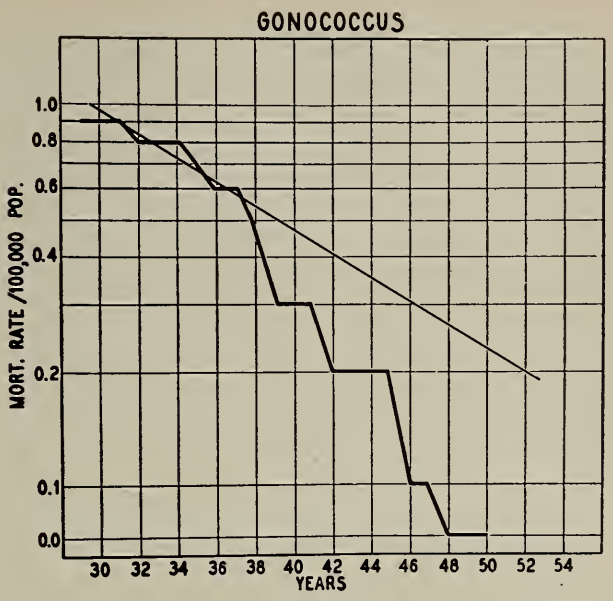
The curve of the mortality rate in acute and subacute bacterial endocarditis is shown in the chart labeled "Endocarditis". It is to be noted



that sulfonamide therapy had no effect in lowering the death rate from these diseases. With the introduction of the antibiotics as therapeutic agents deaths from these causes decreased appreciably.

The mortality rate from whooping cough fell appreciably during the period 1900-40. However, following the introduction of sulfathiazole, the sulfadiazines and the antibiotics, deaths from this cause have declined sharply. Futher decreases may be expected.

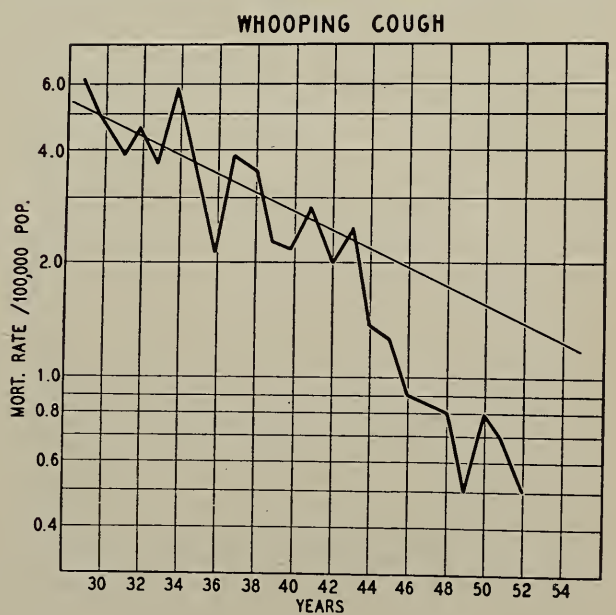
Deaths from gonococcal infections, while not numerous, were decreased in a spectacular fashion following the introduction of the sulfonamides and antibiotics for the treatment of these infections. For three years, a mortality rate of

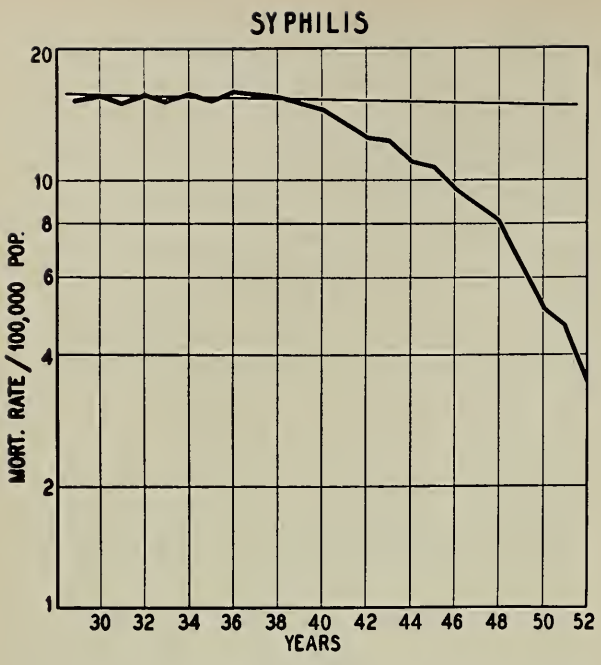


zero has been recorded. It is probably fair to say, that were it not for the moral implications of gonococcal infections, these diseases would be considered much less serious than is the common cold!

The trend of the mortality rate in syphilis is extremely interesting.

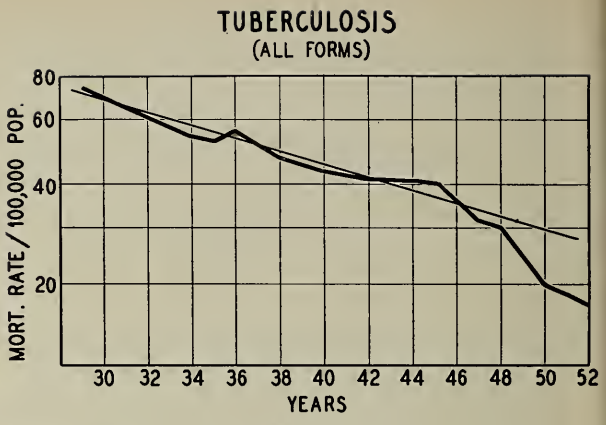
The discovery of Arsphenamine was announced about 1910. However, due to various factors, including the shutting off of supplies of Arsphenamine in this country during World War I, the realistic and intensive use of arsenicals in the treatment of syphilis did not come about, until some time in the 1920's. As the majority of deaths recorded, as being the result of syphilitic infection, are due to cardio-vascular





lesions, paresis, and tabes dorsalis, the mortality from this disease, in any given year, represents the toll of infections contracted ten to twenty or more years previously. Hence, if any given therapeutic procedure is effective in preventing the development of late lesions of syphilis, or curing early syphilis, its effect on the mortality rate should not be noticed until ten to twenty years later. This appears to be just what has happened in syphilis. The mortality rate from this disease dropped appreciably below the trend line in 1942. This decline was slightly accelerated during the next six years, and then declined much more rapidly from 1948 until the present time (1953). One is probably being fair, if one attributes to the therapeutic use of arsenicals in this disease in the 1930's, the decline in the mortality rate noted from 1940-8. However, since 1948 penicillin therapy probably has played an increasingly large role in preventing deaths from syphilis. While it may seem extraordinary, there is every reason to believe that deaths from syphilis will practically disappear in the United States within the next ten years.

Reference to Table 2. will show very plainly that deaths from tuberculosis have been declining at an ever accelerated rate during the past one hundred years. This drop has been due primarily to public health measures. However, in 1949, a definite fall away from the trend line in mortality was noted in deaths recorded from



tuberculosis. Reasonable evidence indicates that this decrease in mortality was due to the therapeutic use of streptomycin in the treatment of tuberculosis. The subsequent use of para-amino salycilic acid and the iso-nicotinic acid derivatives for the treatment of tuberculosis may further reduce the death rate in this disease. It seems reasonable to believe that tuberculosis will cease to be a health problem of major importance within the next ten years.

It is high time that health scientists should take stock of their efforts during the past fifty years and attempt to evaluate the results. In the first place, consideration should be given to the effects of the saving of lives on longevity or expectation of life, and the composition of our population, as such relates to its distribution by age groups. Recent figures derived from those insured in the Industrial Department of the Metropolitan Life Insurance Company, indicate that in the absence of death from military action, expectation at birth in 1951 was 68.42 years as compared with an expectancy of 46.63 years in 1911-12. Thus more than twenty years of life expectancy have been added in the lifetimes of

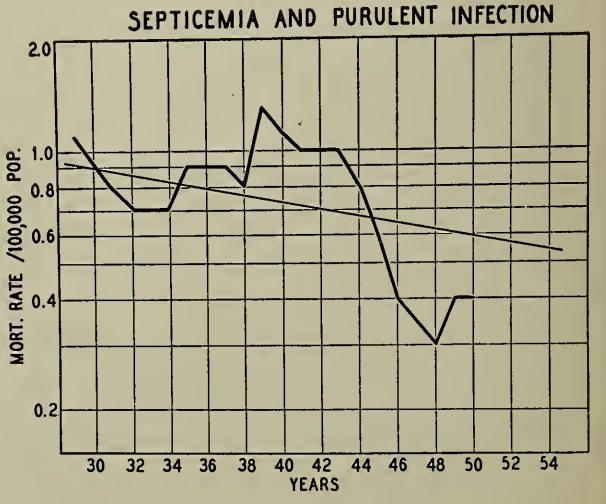


TABLE 4
PERCENT DISTRIBUTION OF TOTAL POPULATION BY AGE

AGE GROUPS	YEARS					
	1900	1910	1920	1930	1940	1950
Under 5	12.1	11.6	11.0	9.3	8.0	10.8
5-19	32.3	30.4	29.8	29.5	26.5	23.5
20-44	37.8	39.1	38.4	38.3	39.0	37.3
45-64	13.7	14.6	16.1	17.5	19.7	20.2
65 and over	4.1	4.3	4.7	5.4	6.8	8.2

most of us. It has also been shown[2] that the efforts of the health scientists in the West (Western Europe, North America) have been so successful, that "future declines in pre-adult mortality can at the best lead to relatively minor gains in life expectancy at birth. . .Even with no deaths under age 15 during the 1940's the median rise beyond the levels actually recorded would only have been about 4 person-years for females and 5 for males." This, it must be emphasized, is less than a quarter of that actually noted in this country since 1920. It appears quite clear that we have almost reached the maximum of increase in life expectancy which can be gained by the control of infectious processes, in the United States. In 1951, but about twenty percent of the deaths occurring in individuals under fifteen years of age in this country were due to infections.

The net result of the savings in life that have been made in the last seventy-five years, and which have increased at an accelerated rate during the past twenty-five years, has been to bring about a considerable change in the age distribution of the population in the United States. This factor, coupled with the fall in the birth rate which persisted from about 1900 to 1940 has been reflected by an increasingly smaller percentage of young people, and a corresponding increasingly larger percentage of older people in our population. A glance at Table 4 shows what these changes have been. Today it is estimated that in a total population of 159,000,000 people, the aged (65 years and over) number more than 14,000,000 individuals, and that possibly within another twenty-five years this figure will reach 24,000,000. To emphasize this further, in New York City alone, there are more than 660,000 individuals aged 65 or over; more people, in other words than comprise the total population of Buffalo, New Orleans, or Houston, Texas.

These changes in our population should cause everyone to stop and think, and especially physicians! The medical profession has solved many of the problems of man's physical ills, but what has it done about his other problems: mental, emotional, cultural, social and economic? It is not enough for us to shrug off the problem by saying, "Well, those are the concern of the psychologist, the social scientist, or the political economist". We have in more than one sense created this situation, and our triumph will be an empty one, unless the difficulties of the older folks are faced, and reasonable solutions found.

It would be beyond the limits of this presentation to do more than "point up" certain of the questions which must be answered. In the medical field, what can be done about cardiovascular-renal disease and cancer? In the economic sphere, what should be done about retirement? What about Social Security? In the psychological field, what should be done about the feelings of loneliness, futility, of not belonging? Emotions which too frequently overwhelm the aged. In the social field, what about living with their sons, daughters, and in-laws? What about communal centers for the aged? What about housing? What about recreation for the aged? These are but a few of the questions which must concern the physician, if he is to escape the reproach of having created a situation without giving thought to the consequences of his efforts.

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Dermatologic Emergencies

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Emergency conditions involving the life of a patient seldom are encountered in the practice of dermatology. However, there are some dermatoses that are semiemergent; proper treatment, when given early and adequately, will obviate the urgency of these conditions. The dermatoses that belong in this group are listed in the accompanying table.

Acute Dermatitis. — Acute vesicular dermatitis caused by contact with poison ivy or any other substance that produces a vesicular or bullous eruption requires emergency measures, not only to relieve the itching but to minimize, if possible, the hypersensitization and thus to limit the spread of the dermatitis. It is for these two reasons that a bland wet dressing is the most satisfactory method of treatment rather than application of greasy medicaments or use of some type of antigenic therapy. The sensitization that develops in much or all of the patient's skin after contact with an irritant results in the development of dermatitis in regions of the skin that did not come in contact with the irritant; this is a most important feature of the problem of acute contact dermatitis. The evidence is conclusive that this factor of hypersensitivity usually is overlooked when the treatment program is started, with resultant overtreatment and further extension or aggravation of the dermatitis.

The words "treatment program" have been used with a definite reason in mind, namely that treatment for acute vesicular dematitis is not specific. It must be changed or modified according to the patient's response and especially according to the degree of sensitization that is present or is developing. It may be necessary to use several different types of mild wet dressings before one is found that gives comfort; this is due to the fact that the dermatitis continues to spread as a result of the sensitization.

Dermatologic Emergencies

Acute vesicular dermatitis; dermatitis venenata
Lupus erythematosus
Urticaria and angioneurotic edema (including edema of the glottis)
Bacterial infections
Cellulitis; furuncles; carbuncles
Erysipelas; erysipeloid
Viral infections
Herpes zoster ophthalmicus
Stasis dermatitis with eczematization

Because of this sensitization, the medication may be accused erroneously of being inefficient or irritating. The wet dressing is not at fault but rather it is the instability and resulting irritability of the skin, as indicated by the development of new vesicles or blisters, which makes wet dressing appear to be ineffective.

Pruritus continues until the degree of sensitization reaches its peak, at which time the mild wet dressings previously used and found wanting because of their inability to afford relief will now be comforting and effective. It is this same phenomenon of hypersensitization that results in exacerbation and extension of an acute dermatitis when ointments containing potent antiseptics, keratolytics or sensitizing chemicals, such as mercury and derivatives of cocaine, are employed. I have used the term "mild wet dressings" rather frequently and recommend as effective members of this group the following forms of medication. (1) aluminum subacetate solution in 0.5 per cent strength; (2) boric acid (less than a saturated solution); (3) dressings wet with isotonic solution of sodium chloride; (4) silver nitrate in 1:2,000 dilution and (5) potassium permanganate in 1:15,000 dilution. The latter is best if secondary infection is present.

If the involvement is extensive, covering much of the trunk, a tub bath may be used containing

Read at the meeting of the Illinois State Medical Society, Chicago, Illinois, May 21, 1953.

From the Section of Dermatology, Mayo Clinic, Rochester, Minnesota.

cornstarch and sodium bicarbonate* or boiled oatmeal and sodium bicarbonate gruel.†

Wet dressings may be extremely effective when properly employed and may be quite useless when put on improperly. A wet dressing, to be effective, must keep the skin wet. This means more than just keeping the gauze and bandage moist, because the medicament, to be effective, must be in constant contact with the skin. In order to maintain the necessary degree of moisture, it is essential that a large amount of gauze be used and that it and the bandage be applied rather loosely so that the solution, which should be used often enough to keep the dressing moist throughout, can be poured on at the open ends of the dressing so that it does not run onto the floor or bed. Removal of the gauze every few hours and complete saturation of it in a basin containing the solution is often advisable. If, when the bandage is removed, the gauze is found stuck to the skin, it is obvious that no good has been done and the purpose of the wet dressing has not been accomplished. A wet dressing should be used almost continuously, rather than for only a few hours a day, until the erythema, edema and vesiculation have disappeared. It is not advisable to cover the dressing with impervious material of any sort, as the dressing must be "allowed to breathe." The solution should be cool or at room temperature when it is applied.

The objections to wet dressings are waterlogging of the skin, the secondary saprophytic infections that sometimes occur and the danger that patients, especially eldery ones, may "catch cold." As a rule, these objections can be overcome by removal of the dressing for half an hour every six hours, thus allowing the skin to dry. Each time this is done, the debris that has accummulated on the skin should be removed by gentle friction with a piece of sterile gauze. Soaking hands or feet in a basin is less effective than a wet dressing because of the edema that develops as a result of the dependent position of the extremity for long periods. It is advantageous if the extremity can be elevated while the wet dressing is worn.

It is not advisable to give injections of foreign proteins, such as vaccines, antigens and serums, to patients who have acute vesicular dermatitis. Occasionally such agents are well tolerated, but more often severe accentuation or even complete generalization of the dermatitis may take place after such a procedure. Therapeutic administration of an antigen from poison ivy has been recommended; although some patients have tolerated it well, such use has been followed on numerous occasions by rapid spreading of the eruption to involve the entire body.

A similar warning is necessary in regard to the application of patch tests in an effort to find the cause of a suspected contact dermatitis. Application to the skin on the patient's back or arm of a chemical similar to or allied to the substances to which he has become sensitive may produce severe exacerbation and generalization of the dermatitis. It is safer to perform these patch tests when the dermatitis has subsided. The use of skin tests employing either intradermal or scratch technics offers no help in a determination of the cause of a dermatitis if the tests are done during the acute phase. The reason for his unreliability in the presence of acute dermatitis is that many false positive reactions are obtained because of the unbalanced state of the skin; thus, positive reactions observed under such conditions frequently are the result of, rather than indicative of the cause of, the dermatitis.

Although the term "diathesis" has lost its widespread application in recent years, nevertheless it is still one of the most satisfactory means to explain the cause of many types of dermatitis. Until accurate information is obtained with regard to the mechanisms that produce cutaneous sensitivity, it will be necessary to grope for the true explanation. Among the purposes of the important field of investigative dermatology is a determination of why a patient is sensitive to

*Make a paste by adding cold water to 1 cup of cornstarch and ¼ cup of baking soda. Put this paste into half a tub of warm water. Bathe the patient for twenty to thirty minutes daily, or less often if the skin continues to dry. Sometimes the cornstarch is boiled before it is mixed with the baking soda.

†Boil 2 cups of bulk oatmeal in 1 quart (960 cc.) of water for thirty to forty-five minutes in a double boiler. Allow to cool for fifteen minutes and add half a cup of baking soda. Pour the entire mixture into a gauze bag, which is then tied shut. Place this in a bathtub that is half or three-quarters full of water at a temperature of 90° to 96° F. (about 32° to 35.5° C.). The patient may stay in the tub for a half hour to two hours, expressing the oatmeal mash through the gauze and applying it to the body. The mash should be washed off thoroughly before the patient leaves the tub. Dry by patting, not by rubbing. The patient may be placed in the tub for several hours two or three times in twenty-four hours, especially if the water is kept at a temperature of 97° to 100° F. (about 36° to 38° C.).

a substance rather than merely to uncover the fact that he is sensitive to it.

A tendency for development of dermatitis is often a familial characteristic for which the word "allergy" has become widely used. Many infants who are "born to eczema" exhibit dermatitis shortly after birth and may be condemned to a life of intermittent eczema, although some children tend to control it at the time of puberty or sooner. Dermatologists use the term "atopy" when discussing such children.

Dermatitis on exposed cutaneous surfaces is not always caused by irritating agents in the patient's occupation, although it should be borne in mind that persons who have had dermatitis in infancy and adolescence, the so-called atopics, are especially liable to occupational dermatitis. By the same token, the atopic patient who experiences dermatitis a week or two after starting work on a new job might well have a return of atopic dermatitis rather than a new occupational or contact dermatitis. Only a slight trigger effect may be needed to precipitate another attack of dermatitis in an atopic person; frequently the ordeal and worry of a new job rather than contact with some irritant in his work may cause recurrence of the difficulty. Such flare ups are not occupational in origin and these patients are not entitled to long periods of compensation.

When the acute process has subsided, as indicated by the absence of vesicles and bullae and the presence of scales and crusts and perhaps superficial ulcerations, use of wet dressings may be discontinued and a mild ointment may be applied. One of the more commonly used agents of this type is an ointment containing 3 per cent ichthammol (ichthyol) in zinc oxide. Another favorite is calamine lotion, followed by an application of cold cream.

Burrow's paste, which has been used widely, is made up as follows:

Burrow's solution	10.0
Hydrophilic ointment, U. S. P.	20.0
Zinc oxide paste, to make	60.0

Proprietary preparations used for this purpose include such agents as aquaphor and polysorb. Baciguent, which contains bacitracin, is a mild ointment that has antibiotic features.

Use of protecting ointments for persons who are subject to occupational dermatitis has some value, especially while the worker is overcoming sensitivity to irritants in his work. In industry this is known as "skin hardening." If this loss of sensitivity does not occur, the patient should change jobs.

Lupus Erythematosus. — Two types of lupus erythematosus exist, namely the chronic discoid and the disseminated, or systemic type. Because the patient's life may be at stake, the latter form of this disease occasionally assumes emergency features even though its cause is not known and a specific curative agent is not at hand.

Lupus erythematosus of the systemic type may develop in a patient who has had the chronic discoid form of the disease for many years. The transition from a benign localized affair into a fulminating fatal disease may take place because of such things as severe sunburn or pregnancy; in other cases, no obvious reason can be found. The dermatologic picture of systemic lupus erythematosus varies from a severe, edematous and superficially ulcerated eruption of the face and upper part of the thorax to only a faint blush involving both cheeks. Accordingly, the dermatologic picture does not always indicate the severity of the systemic disease, which may prove fatal in patients who have relatively insignificant cutaneous lesions. Similarly, the extent of the eruption does not indicate the severity of the disease, because patients who have the chronic discoid type will on occasion exhibit numerous lesions scattered over the upper part of the trunk and the arms and legs and still not display any evidence of systemic involvement.

Among the factors that determine the seriousness of systemic lupus erythematosus are the following: (1) presence of fever; (2) increase in erythrocytic sedimentation rate (60 to 120 mm. during the first hour, Westergren method); (3) leukopenia; (4) urinary findings indicative of nephritis and (5) presence of the L.E. cell. To these may be added the history of episodes of joint pains (arthralgias) that may date back for several years, associated with periods of disability, unexplained fever and loss of weight. These laboratory and clinical data, irrespective of the degree or type of cutaneous lesions, create the picture of systemic lupus erythematosus.

The emergency features in this disease include the need for early recognition, institution of bed rest, avoidance of sunlight and the use of therapy with corticoid substances. Mention has been

made of the fact that the cause of lupus erythematosus is unknown and that no specific therapeutic agent exists; nevertheless, administration of cortisone has lifted many patients over the obstacle that separates the acute from the subacute form of the disease and thus has prolonged their lives, although they have not been completely cured of their disease. The finding of the L.E. cell has broadened concepts of systemic lupus erythematosus by extending the base of knowledge concerning this disease; thus some bizarre clinical entities that heretofore went unrecognized now are included under this diagnosis.

Urticaria. — Urticaria assumes emergency features when edema of the glottis or tongue develops. Since introduction of the antihistaminics, these complications occur less frequently; however, their possibility must be borne in mind, together with the fact that tracheotomy may be necessary to save life when an antihistamine given orally or intravenously has not reduced the edema. Use of epinephrine in the treatment of urticaria has decreased since the introduction of the antihistaminics, primarily because results from its administration are incomplete and of short duration.

Infections. — Cutaneous infections such as erysipelas, furuncles, carbuncles and extensive impetiginous lesions also have lost their semiemergency features since the introduction of the antibiotics. It is a rare occasion when any of these infections fails to respond to administration of one or the other of the antibiotics. The ideal situation is to obtain the organism in cultures, determine its type and then use an antibiotic to which the organism is sensitive. Rarely is it necessary in infections of the skin of this type to test for sensitivity.

Streptococci are responsive to penicillin, aureomycin and terramycin, but they may develop resistance to any of these agents[1]. Micrococci (staphylococci) may develop resistance to penicillin in as many as 60 per cent of cases, while resistance to streptomycin, aureomycin and terramycin may appear in as many as 40 per cent of cases. Thus far, streptococci and micrococci (staphylococci) have shown a minimal tendency to become resistant to erythromycin, which has been used but a comparatively short time; however, a longer period of observation with more clinical material is necessary before this feature of erythromycin is evaluated. Accordingly, patients who have erysipelas, carbuncles, furuncles or extensive impetiginous lesions, should receive aureomycin first, because it has a low degree of sensitization; if the response is slower than anticipated, erythromycin then may be used. It is not advisable to give two antibiotics concurrently for infections of this type, because they may be antagonistic to each other.

Herpes zoster. — Herpes zoster becomes an emergency situation when it involves the ophthalmic branch of the trigeminal nerve, with the possibility of corneal involvement (herpes zoster ophthalmicus). Pain, which precedes, for three to seven days, the onset of the herpetic eruption, usually is less severe than that occurring in thoracic herpes zoster; however, the pain that follows the healing of the eruption may be severe and incapacitating. In addition, involvement of the cornea by herpetic vesicles may result in loss of vision in the affected eye.

The interval from the appearance of the first herpetic vesicle to the maximal development of the eruption is seven to ten days in herpes zoster ophthalmicus and less in cervical or thoracic lesions. In addition, the occurrence or gangrenous ulcerations of the scalp in not uncommon.

Although specific agents against the virus of herpes zoster are not available, nonspecific measures may minimize the attack. Administration of cortisone in doses of as much as 200 mg. a day did not decrease the severity of the condition. Aureomycin or erythromycin may be given to reduce the amount of secondary infection in the scalp. Autohemotherapy may have some merit also. This consists of the withdrawal of 10 cc. of blood from the patient and the immediate injection of 5 cc. of this blood into each buttock. These patients are sick and should be kept in bed and protected from sudden changes in the temperature of the room. A drying lotion, such as calamine lotion, applied to the scalp is more satisfactory than use of greasy preparations, although suggestions in this regard vary according to the degree of infection that develops in the scalp.

Medication for the pain is given according to its severity. The most troublesome part of herpes zoster is the postherpetic neuritis that may last for months and may require constant use of

opiates. Roentgen therapy to the dorsal nerve roots, intravenous injections of sodium iodide or administration of double-strength posterior pituitary injection (pituitrin S) are also worthy of trial.

Stasis Dermatitis. — Stasis dermatitis, or eczema of the lower parts of the legs as a result of varicosities, previous thrombophlebitis or any factor that disturbs the circulation in the leg, occasionally presents emergency features. Stasis dermatitis, which may remain localized to the lower parts of the legs for years, occasionally results in auto-eczematization and the development of eczema scattered all over the surface of the body. The process of auto-eczematization, although readily recognized, is not thoroughly understood, by which is meant that it is not known whether secondary infection, the presence of serum and secondary scaling features, treatment or some unknown factor results in a disturbance of cutaneous equilibrium and the development of eczema on the trunk and arms. When hypersensitization becomes great enough, generalized eczema may result. When dermatitis begins to appear on the trunk, arms and face of a patient who has had dermatitis and possibly ulcerations on the lower parts of the legs as a result of circulatory disturbances, it is necessary that such extension be considered emergent. Treatment, which should be directed primarily toward the legs, consists of rest in bed with the feet elevated and applications of wet dressings and mild ointments. As the dermatitis of the legs improves, the eruption on the arms and trunk will do likewise; when the skin of the legs is approaching normal, the patient again may become ambulant, provided he wears supportive bandages on the legs. These bandages may be made of Pará rubber, elastic stocking or linen wrap legging; they should be worn whenever the patient is out of bed.

SUMMARY AND CONCLUSIONS

Only a few dermatologic conditions are of an emergency nature. Those most frequently encountered are acute vesicular dermatitis, lupus erythematosus, urticaria and angioneurotic edema, infections, herpes zoster ophthalmicus and stasis dermatitis with auto-eczematization. Life may be threatened in lupus erythematosus and in edema of the upper part of the respiratory tract as the result of urticaria or angioneurotic edema. In the other diseases, emergency measures may prevent development of severe complications or long periods of illness but they are not lifesaving.

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THE CAUSE OF GALLSTONES

It seems entirely reasonable to suppose that gallstones are formed simply from excessive concentration of bile due to its prolonged stay in the gall bladder. Formerly, it was considered that infection played a part and the occasional finding of a typhoid bacillus or other organism at the center of a stone was presented as proof of this hypothesis. Now, however, such bacteria are rarely if ever found in stones and except in acute secondary infections, gall bladder bile is found to be sterile with no evidence of infection of the gall bladder wall demonstrated. There is no doubt, however, that chronic or repeated infection or allergic reactions in the gall bladder and ducts may cause sufficient organic changes to interfere with proper function, produce stasis, and favor the formation of stones. *Albert F. R. Anderson, M.D., Therapeutic Implications in Gallstones., New York J. Med. Aug. 1, 1953.*

Physiologic Basis for Choice of Parenteral Fluids in the Surgical Patient

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During the past quarter century there have been many advances in technical surgery which have extended the advantage of surgical intervention to patients with diseases heretofore considered irreversible. Such has been the progress that no organ or organ system is beyond the reach of some surgeon's attack. Clearly, this is in no way due to the assumption that the surgeon of today has greater personal technical ability than such surgeons of yesterday as Mott, Dupuytren, Kocher and Halstead — for such is not the case. Surely, abundant evidence is at hand in the ever growing surgical literature that technical advances are consequent upon the fuller appreciation of basic physiologic principles and their practical applications in the care of patients in health and disease. The physiology of the dynamics of circulation and respiration, of the normal constituents of blood, of blood substitutes, of normal and abnormal renal function, and of nutrition in all its phases — all of these things are the foundation of modern surgery. Because knowledge of all these factors with which the trained surgeon of today must be familiar in order to care for not just the diseased organ, but rather for the entire body economy, his work begins much before the patient comes to the operating room and does not cease until long after.

Amongst the most basic and fundamental considerations in the care of patients is the knowledge of the body's normal maintenance requirements of those substances which constitute his internal environment, and of how they deviate from normal in disease. It is proposed herein to highlight those deviations and make recommendations for their correction.

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Outline

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 B. Electrolyte). .Balance .
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III. Abnormal Dynamics with Abnormal Kidneys
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Water Balance.—The body is composed by weight of 65%-70% water. The water is distributed into three compartments: — (1) Intracellular (2) Interstitial (3) Circulating Fluid; the latter two compartments constitute the extracellular fluid. In an average individual of 150 pounds the relative distribution of water is shown in Figure 1.

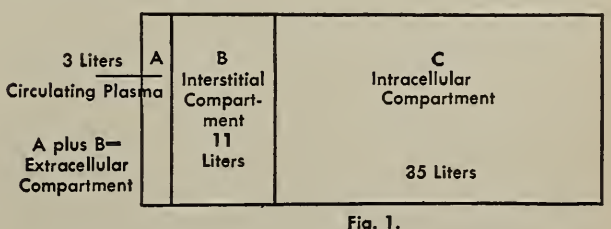


Fig. 1.

Exogenous intake of fluid and the liquid content of solid food constitute the source of supply of 90% of body water. The remaining 10% comes from the endogenous water of oxidation and the shift from chamber to chamber.

Loss of water from the body is by various

routes and subserves different function: —

1. Loss from the skin subserves the function of dissipation of heat.
 A. Perspiration, visible — changes readily with availability of supply and with external environment.
 B. Vaporization, invisible — affected very little by supply. Varies from 1000-1500 cc daily.
2. Urine subserves the function of providing a diluent for the excretable products of metabolism, averaging about 35 grams daily. For this purpose a urinary volume varying between 1000 cc at a specific gravity of 1.020 to 1500 cc at a specific gravity of 1.010 is necessary.
3. Lungs vaporize 200 to 500 cc daily.
4. Stool carries out 100 to 500 cc daily.
5. An additional amount must be allowed for water loss on the basis of:—
 A. Body temperature elevation which increases visible perspiration.
 B. Direct fluid loss, measurable, by vomiting, diarrhea, fistulae and gastr-intestinal drainage.

Electolyte and Acid-Base Balance.—The normal electrolyte pattern consists of a predominane of the sodium ion and the chloride ion. The chloride ion is ubiquitous, whereas the sodium ion is the predominant cation in extracellular fluid. The normal blood and urine findings are as follows:—

Serum sodium—315-340 mgm% or 136-145 meq/Liter

Serum Pottassium—16-22 mgm% or 3.5-5 meq/L.

Serum chloride (as NaCl)—570-620 mgm% or 96-105 meq/L.

Urine sodium—same as blood

Urine potassium—150 mgm% or about 35 meq/L.

Urine chloride—550-700 mgm%

The pH of the blood in health varies little from 7.45. It is determined mainly by (1) the ratio of the cencentration of the bicarbonate ion, HCO_3^-, and of carbonic acid, H_2CO_3 (2) the relative proportions of the biphosphate ion, $HPO_4^=$, and the acid phosphate ion, $H_2PO_4^-$ and (3) by the relative availability of Cl - ions and the sodium ions. From the table it is apparent that the blood serum and urine concentrations of sodium and of chloride in health are almost identical. One might assume from this fact that any excess intake of these substances under such conditions would be quantitatively excreted in the urine. Such is found to be the case when the kidneys are functioning perfectly. In depletion of either substance, the deficit would be retained and the excess then excreted if water is made available. Notice that potassium is found in greater concentration in the urine than in the blood; this would suggest that blood potassium is relatively stable and that the urinary excretion of potassium parrallels its ingestion. Such is actually found to be the case, in the presence of normal renal function.

In alkalosis the pH of the blood rises. The most common cause of alkalosis is vomiting which results in a loss of chlorides from the stomach. When HCl is removed by vomiting there will be a relative excess of Na_2HPO_4 and $NaHCO_3$, both basic, and this constitutes the alkalosis. The treatment of this condition is to supply the deficiency of chloride as NaCl, and the kidneys will excrete the excess sodium ion as $NaHCO_3$. It has only recently been appreciated that the replacement fluids should contain some KCl also, because with every chloride loss there is some concomitant potassium loss.

In inorganic acidosis there is an excess of chloride due to an excessive loss of sodium. The main clinical causes are (1) diarrheas (2) intestinal fistulae (3) biliary fistulae. The treatment consists in replacement of lost sodium as $NaHCO_3$ or preferably as M/6 sodium lactate-Ringer solution.

Acidosis may be organic in nature as a result of the metabolic arrest of carbohydrate oxidation; this is the clinical state of ketosis. The lowering of the pH of the blood is a direct result of the presence of ketone bodies — beta hydroxy butyric acid, di-acetic acid and acetone — which replace the HCO_3^- ion. Proper treatment involves the adequate replacement of base and glucose, with provision for more complete oxidation of the latter. If, in addition to the organic acidosis (ketosis) there is water depletion inorganic alkalosis may be coexistent. If so, treatment requires all four elements — water, base, chlorides and glucose.

Dehydration with Normal Kidneys.—Consideration of the foregoing factors responsible for normal fluid and electrolyte homeostasis will

readily point out the fact that dehydration is not just one thing. Rather, what has been called dehydration falls into two distinct categories of (1) water depletion and (2) salt depletion. Either of these may exist by itself and the two may coexist.

Water Depletion.—This condition occurs particularly when water is withheld or a deficient amount is ingested. Under such conditions the extracellular compartment becomes temporarily hypertonic. The body adjustments that take place to compensate for this altered state are: (1) water flows from the intracellular compartment to the extracellular compartment (2) the urinary output is diminished. Thus, there is temporarily a normal serum chloride concentration because of the shrunken intracellular compartment. Figure 2.

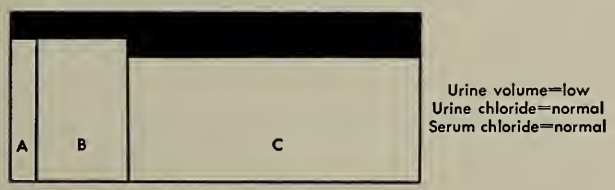


Fig. 2. Water Depletion

Salt Depletion.—When there is excessive chloride loss as in profuse and protracted perspiration and in uncompensated gastro-intestinal losses, the extracellular chamber becomes hypotonic. The body adjustments that take place to compensate for this altered state consist essentially in the excretion of excess water without a corresponding amount of salt. This contraction of the extracellular compartment becomes serious because the circulating fluid, a part of the extracellular chamber, is diminished. The diminished circulating volume constitutes shock, acute of chronic, depending on the rapidity of the precipitating loss. Figure 3.

Thus, it is clear, that providing renal function is good, the urine will reflect these changes even before the circulating blood will. In the case of water depletion there will be a diminished urinary output with a normal chloride content. In the case of salt depletion there will be an abnormally low urine chloride concentration.

Does a simple urine test exist for the differentiation of these two conditions? Yes — providing the patient has normal kidneys and adrenals. The Fantus test is adequate under such conditions; it is simple to perform and should be available at every nursing division in the hospital. To gain the information desired one must know the urine volume and the concentration of chlorides in the voided specimen. The normal urine chloride concentration is around 550 mgm.% or 5.5 grams per liter (approximately the same as blood). Any finding of 3 grams/liter (300 mgm.% or 0.3%) or more one may assume that there is no serious loss of chlorides. Under these circumstances one would start the correction of dehydration with glucose in water or other solutions low in chloride content. If the urine chloride concentration has fallen below 3 grams per liter (less than 0.3%) there is a definite indication for the administration of saline solution. If the urinary chloride concentration is so low that it approaches zero, one must then resort to serum

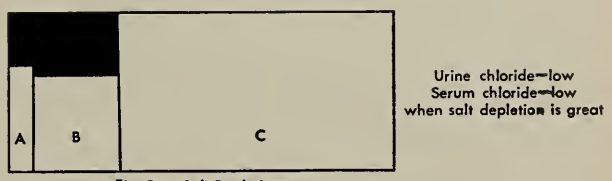


Fig. 3. Salt Depletion

chloride determinations since such very low figures may be a result of renal disease or cardiac decompensation. In patients with such complicating factors operative the use of clinical judgment is called upon — eyeballs, tongue, skin, etc., — in the evaluation of the patient. It must be borne in mind that by the time one recognizes well established dehydration clinically the patient has already lost at least 6% of his body weight. The urinary findings would have detected these deficiencies long before.

The Fantus test is extremely easy and may well be done by the floor nurse. The ingredients are (1) 20% potassium chromate (2) 2.9% silver nitrate. One places in a test tube 10 drops of urine and one drop of the chromate, which is an indicator only. Then one places one drop at a time of the silver nitrate in the tube, which is all the while being agitated, until there is a sudden change from yellow to brick red. The number of drops of silver nitrate used to obtain this change is the number of grams of chloride per liter in the urine; thus, 3 drops to bring the change means that the urine chloride figure is 3 grams per liter.

Potassium Deficiency.—Until recent years the

importance of potassium loss and replacement has not been appreciated. When there is a great chloride loss, the chloride is accompanied not alone by sodium, but by some of the intracellular potassium as well. In the following states there is an appreciable loss of the potassium ion: — excessive salt depletion, starvation, during the postoperative period when nutrition is by the parenteral route, and most especially when there is bowel obstruction and/or ileus of long standing.

The diminution of normal potassium levels of 4.5 meq/liter leads to anorexia, lassitude and profound muscular weakness, including myocardial weakness. The improvement in such a post operative patient on the administration of 2-4 grams of KCl is remarkable. It may be given by the gastro-intestinal route or parenterally. Ampouls of KCl, 20 meq. in 10 cc are available commercially; this corresponds to 1.49 grams of KCl. When the potassium deficit has existed for days or weeks, instead of the usual 40 meq. per day, as much as 120 meq. (6 ampouls) or even more may be required. The flame photometer makes rapid determinations of serum potassium possible. Electrocardiographically, evidence of hypopotassemia or of hyperpotassemia is readily detected. Recently, potassium acetate solution has been made available, 5 meq. per cc, to avoid administration of the chloride ion when it is not desired.

Abnormal Dynamics with Abnormal Kidneys. —The presence of diminished renal function not only complicates the patient's fluid and electrolyte control by the doctor, but constitutes a complication which is a threat to the patient's life and demands therapeutic considerations in its own right. The surical patient may have renal insufficiency on a pre-renal, a renal, or a post-renal basis. The concomitance of disease such as glomerulo-nephritis and nephrosclerosis (renal) requires the cooperation of the medical colleague. The essential irreversibility of these diseases will often preclude surgical intervention other than emergent in character. The diminution of renal output on the basis of obstruction in the ureters or as a result of prostatic obstruction (post-renal) demands their immediate correction by appropriate means. It is the prerenal causes of anuria and/or oliguria —— specifically shock—which most interests the surgeon in the struggle for a normal water and salt status. Although probably only partially due to changes in vascular pressures (and partly due to the effect of anesthesia on the kidneys) the postoperative period is a special type of anuria/obliguria. It will be discussed separately.

Anuria and /or Oliguria.—Anuria or oliguria may be met clinically following accidental trauma, surgical trauma, or spontaneous bleeding such as encountered in massive gastro-intestinal hemorrhage as a result of esophageal varices or peptic disease. It is best considered in its component phases.

Phase I:—The period of actual hypotension. Such a state, from whatever cause, must be corrected as soon as possible, and preferably with whole blood. The severity of subsequent renal decompensation, other things equal, will depend on the duration of serious hypotension.

Phase II:—This is the phase of actual anuria — total absence of urinary excretion, or oliguria — diminished excretion of urine. Here serious errors have been made that sealed the fate of such not-yet to be forsaken patients. These errors have been on the side of overly vigorous treatment by an attempt to force the kidneys to "put out" by trying to force the filtration pressure into higher levels. Under such attempts not a few patients have died cardio-respiratory deaths from an over-taxed heart and water-logged lungs, because the spigot at the bottom of the barrel (the kidneys) would not thus be blown out. The kidneys cannot be thus forced to open up. It is, therefore, mandatory that during the period of actual anuria/oliguria fluids be kept at a minimum — an amount equal to the output from the skin and lungs (1500-2000 cc/day). Caution must be exercised against the occurence of acidosis, and if it is detected by blood studies, must be corrected with bicarbonate or lactate solutions. Caution must also be exercised in the matter of observation of muscular twitching. Although this phenomenon may occur with uremia per se, it may also be due to diminished calcium ion concentration, which can easily be replaced. Also the accumulation of the potassium ion in the blood in renal decompensation should be remembered. "Stay on the dry side" is the proper watchword of this period.

Phase III:—This is the period of recovery of

kidney function. It is characterized by diuresis which may reach spectacular proportions. The danger in this period is the washing out of too much salt as nature temporarily overswings the pendulum. The excess salt lost in the urine during these two or three days must be replaced, not quantitively but largely.

Phase IV:—This period witnesses the gradual recovery of normal renal function as the blood picture shows the daily reduction of azotemia. No specific therapy is necessary.

The Post-operative Period.—During the first 24 hours after an operation and sometimes during the first 48 hours, the kidneys are unable to excrete excesses of either water or salts, particularly the sodium ion. It behooves the surgeon to stay his hand in ordering too much fluids during this short period. Coller suggested in 1940 that a good postoperative fluid is one containing 0.38% saline solution and 0.11% bicarbonate. Lichtenstein has suggested that a 0.45% saline solution is a better and safer all around preparation than the so-called normal saline. Some surgeons have come to use intravenous solutions postoperatively that contain no sodium whatever.

PROTEIN DYNAMICS

A. Normal Dynamics.—The normal total protein value in the serum various from 6 to 8 grams per 100 cc., and represents a balance between supply, storage and catabolism. Approximately two-thirds of this amount is the albumin fraction and one-third is the globulin fraction. The albumin is much the smaller molecule and is the important factor in maintenance of hydrostatic pressure and therefore in hypoproteinemic edema of tissues. The globulin fraction is dependent upon good liver function and may contain elements of importance immunologically.

B. Debility and Repair.—During periods of increased catabolism circulating proteins are used to rebuild destroyed tissue, and they in turn are replaced by storage proteins. Even when there are no proteins in storage, the protein utilized will be from ingested protein — given an adequate caloric intake. If the caloric intake is not adequate ingested amino acids will be used for conversion to energy. Under such conditions weight loss will be sustained. Thus, there are two conditions when the real body protein reservoir cannot be accurately assessed from the concentration of circulating serum proteins:—(1) in liver disease when the proteins cannot be properly processed (2) during periods of an inadequate caloric intake.

Causes of Hypoproteinemia

1. Inability or failure to ingest
2. Impaired digestion and /or absorption
 a. Chronic diarrhea
 b. Intestinal fistula
 c. Gastro-intestinal siphonage
 d. Intestinal obstruction, where the intraluminal fluid is just as lost to the body economy as if it were lost by routes b. or c. above.
 e. Peritonitis, due to the associated ileus
3. Inadequate Synthesis — Liver disease
4. Increased catabolism
 a. Fever
 b. Elevated BMR
5. Increased protein loss
 a. Ascites
 b. Nephrotic syndrome
 c. Trauma, anesthesia, anoxia
 d. Hemorrhage
 e. Burns

C. The Significance of Hypoproteinemia.—Pack and Rhoads have shown that the diminution in circulating proteins of even 1 gram % is more serious than appears on the surface, particularly in debilitating disease such as carcinoma. In an average weight individual with 6000 cc of blood or about 3000 cc of serum, the reduction of the circulating proteins by 1 gram % means that only 30 grams have disappeared from the circulation. However, given a normal status to start with, that is, an individual with some protein storage, there will be no diminution in circulating proteins until the stores have been depleted. The above mentioned workers point out that before there is 1 gram lost from the circulating fluid there has been a depletion of 30 grams from the protein stores (liver and muscle). Therefore, since there were 30 grams lost from the circulation, the minimal actual loss of protein is 30 x 30 or 900 grams of actual loss of protein is 30 x 30 or 900 grams of protein. These two pounds of protein loss, plus further loss of energy in the process, plus associated water loss indicate a loss in body weight of 6 to 10 pounds. Careful questioning of the patient with the 1 gram % deficit of

serum proteins will not fail to reveal this weight loss (exception, of course, is the case of water retention such as in cardiac decompensation or sodium retention in associated renal disease).

The distinction of being the most important protein in the body, if it is possible to assess degrees of importance, belongs to the special protein hemoglobin. In the hypoproteinemia of debility there is almost always an associated depletion of hemoglobin proteinate. When protein is replaced in any such combined depletion, the hemoglobin exercises priority; its demands must first be met before the level of circulating proteins will rise. The copper sulfate falling drop test may be used to assess both values approximately, in a patient seen for the first time, or may be used to follow the progress of a patient from hour to hour or from day to day, assuming that hydration is adequate. A serum specific gravity of 1.027 means roughly 7 grams % of protein and 15 grams of hemoglobin. For each 0.0029 fall in specific gravity there is a deficit of 1 gram % protein in the serum.

It is always to be remembered it is possible to have hypoproteinemic edema and yet have a normal total serum protein report from the laboratory. This situation obtains when there is, in addition to the decreased albumin concentration, a marked elevation of the globulin concentration — and is found in multiple myeloma and some forms of hepatic disease.

The necessity for supplying an adequate caloric intake while proteins are being replenished has been alluded to before. Ravdin and Walker have pioneered in emphasizing this all too frequently overlooked essential. By detailed nitrogen metabolism studies they have shown that amino acids supplied parenterally were used largely for energy requirements until sufficient calories were supplied to spare the proteins for their intended anabolic purpose. Parenteral caloric intake may be boosted by the use of glucose, invert sugar, and alcohol. The use of alcohol intravenously has not yet attained the position it merits, even though some of us have used it extensively for a long time. Alcohol postoperatively is an excellent sedative, in addition to its caloric value, when a blood level of 80 mgm% is quickly built up. This is accomplished by giving the first 200 cc of a 5% or 7½% solution in the first 15-20 minutes (150-180 gtts/min) and then slowing down to 80 gtts./minute.

The advisability of using these adjunctive measures to provide sufficient caloric intake in order not to waste amino acids may be appreciated from a consideration of basic metabolic facts. The resting metabolic requirements of an adult are 25 Calories/Kd/day. For normal activity of rolling around and moving the extremities in bed another 30% of that figure must be added. For each one degree of fevor another 8% of the original figure must be added. In addition, if alcohol is given, another 8% must be added for its stimulating effects on BMR. Thus, for a 70 Kg. individula:—

70 x 25 C.	1750 C (BMR)
30% x 1750 C.	525 C (bed activity)
16% x 1750 C.	280 C (2° fever)
8% x 1750 C.	140 C (use of alcohol)
	2695 C—Total/day

It is not always necessary to keep the patient from loosing any weight, which means that we may not have to supply all 2695 calories to prevent use of amino acids for energy. However, witness how futile it is even to attempt to come close to that figure with the usually employed 2000 cc of 5% and 1000 cc of 10% glucose, which combined supplies 800 calories (200 grams x 4C.). With the use of 10% invert sugar (dextrose and levulose) and amino acids and alcohol, it is not difficult to supply 1800-2000 calories parenterally, daily. By these methods the conversion of an acute hypoproteinemia to a cronic hypoproteinemia with its dire results of edema, diminished wound healing, diminished resistance to infection and further impairment of liver function, can be prevented.

SUMMARY AND CONCLUSIONS

1. The importance of appreciating the normal dynamics of the body's internal environment in the care of surgical patients is emphasized.
2. Water depletion and salt depletion are differentiated; acidosis and alkalosis are traced pathogentically. The proper fluids and electrolytes for the correction of these conditions are suggested.
3. The importance of the assumption of normal renal function in the interpretation of laboratory data is brought out.

4. The importance of keeping patients with anuria or oliguria and patients in the immediate postoperative period "on the dry side" in order not to overload the vascular system is emphasized.
5. The significance of hypopotassemia in the surgical patient and its correction is discussed.
6. Protein metabolism in health and in disease is discussed. The causes and results of hypoproteinemia are developed. Specific recommendations for its prevention and correction are detailed.
7. Modern surgery is based on physiologic principles. Intelligent use of parenteral alimentation in the surgical patient demands the understanding and application of these basic concepts.

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SEX OFFENDER

A problem at present arousing a great deal of attention in this country is that of the sex offender or sex criminal. The widespread anxiety has been stimulated by an apparent increase in sex crimes, an increase not substantiated by valid statistical reports, and more especially by the detailed and often gruesome publicity in the press about sex maniacs and sex crimes. A great amount of experimental study to prevent, to recognize, and to handle the sexual deviates effectively is under medical attention in the interest of public security. The so-called sexual degenerate or psychopath cannot be sharply defined either in law or administrative practice nor do we as physicians have any consistent criteria for the classification of these aggressive and perverted sex offenders. *Hans N. H. Reese, M.D., and Edward R. Hodgson, M.D., The Psychiatrist in Court. Wisconsin M.J., Jan.* 1953.

Summary of the Chemistry and Physio-Pharmacological Action of the Adrenal Cortical Steroids

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The "Emergency Theory" of Cannon first elaborated in 1914 stipulated that when an animal was subjected to conditions of stress such as anger, pain, or fear, large quantities of epinephrine were found in the blood stream because of a reflex discharge of the adrenal medulla. The work of Selje threw further light and interest upon the compounds produced by the adrenal glands. At the present time more than 50 compounds have been extracted from the adrenal cortex, all of them having the same basic structural nucleus as cholesterol. Generally speaking, these can be classified into three major categories:

1.) Those containing no oxygen atom on the C-11 position, such as DOCA.
2.) Steroids with an oxygen atom on the C-11 position, such as Cortone®, (Compound E,) (11-dehydro-17—hydroxycorticosterone)
3.) Hormone-like steroids such as androgen, estrogen, and progesterone.

Antirheumatic activity of any one of the above mentioned compounds is intimately related to its specific chemical structure. After extensive chemical and therapeutic investigation it has been shown that there are a few basic structural characteristics necessary for antirheumatic properties:

1.) A hydroxyl or ketone group at C-11. (Compound S lacks one of these groups and therefore shows no antirheumatic activity).

2.) A hydroxyl group at C-17 and C-21. (Compounds A and B lack this group at C-17, therefore they lack cortone activity).

3.) A double bond between C-4 and C-5. (Dihydro-cortisone lacks this, therefore it also lacks antirheumatic properties).

4.) A ketone group at C-3 and C-20.

When all of the above chemical structural characteristics are met, the resulting steroid has antirheumatic value. Cortone® and compound F (17-hydroxi-cortico-sterone) are the only steroids presently known which meet these requirements.

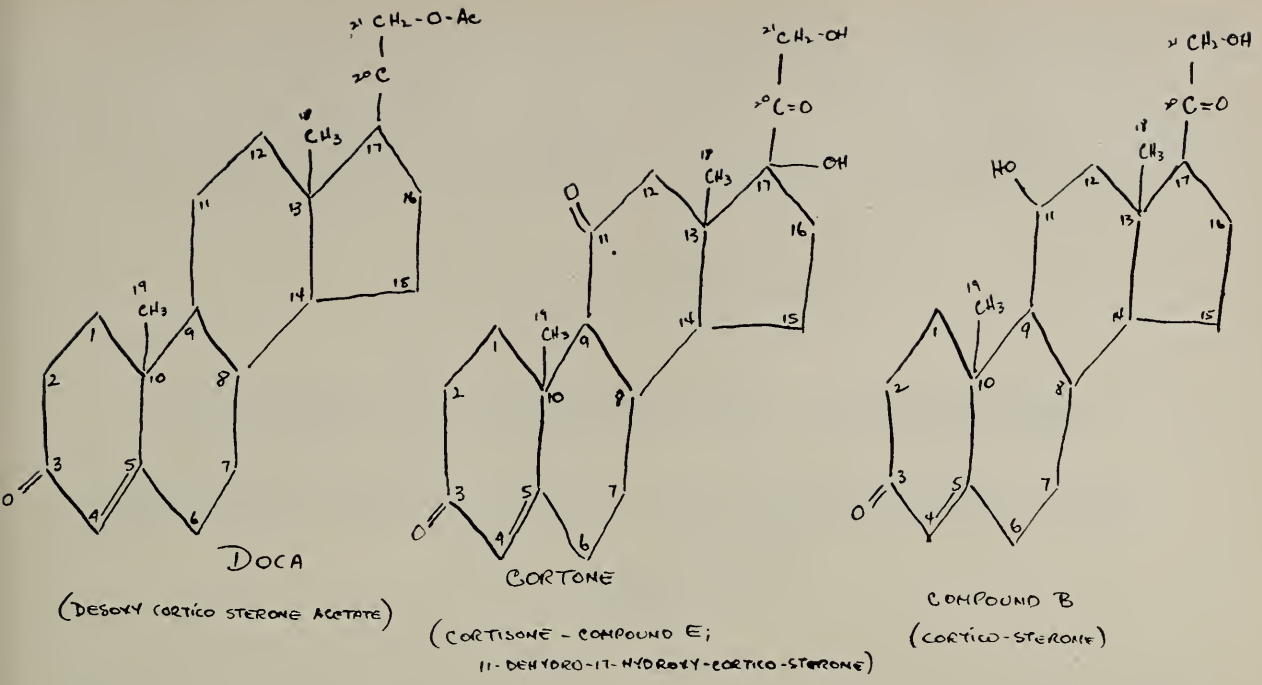
Certain important metabolic charges take place upon administration of therapeutic dosages of Cortone® or ACTH.

1) A fall in the eosinophil and lymphocyte count.
2) An increase in uric acid excretion and uric acid/creatinine ratio.
3) Increase in sodium and potassium excretion with single doses; retention with repeated doses.
4) An increase in blood sugar and a glycosuria.
5) An increase in urinary 11-oxysteroids.
6) A decrease of glutathione levels.
7) DOCA causes sodium retention and a decrease of potassium in the plasma, together with pituitary inhibition.

On the basis of the above and other established clinical experiences ACTH and Cortone® are contra-indicated in:

1) Hypertension, because of elaboration of water-retaining hormones.
2) Diabetes mellitus, since it may make it insulin-resistant.
3) Chronic nephritis, because the sodium and water retention makes the disease worse.
4) Psychotic personalities, since it may produce convulsive seizures.
5) Hirsutism, since it may be aggravated due to increased androgen production.
6) Peptic ulcer, since it may cause further ulceration of the G. I. tract.

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7) Tuberculosis, since it may cause an increase in the disease process.
8) Congestive heart failure, because of increased sodium and water retention.

CASE REPORT

C.Z., a thirty-five year old, white, married female, was first seen during her present illness in the out patient department in acute distress. Respirations were slow and shallow, color ashen. A few moments after entering, she had short periodic tetanic seizures, lasting about thirty seconds. The impression of the intern at that time was: alkalotic tetany. She responded well to 1 cc. of Coramine® intravenously and was admitted to the hospital.

Her husband gave the following history: For the previous two months she had been nauseated and gradually losing weight, approximately thirteen pounds, with marked weakness. Five days prior to admission, she had been unable to retain food including liquids for more than five minutes. The nausea and vomiting were accompanied by mild paraumbilical intermittent pain. During this two month period her husband also stated he had noted an intermittent "jaundice".

Three weeks prior to this admission the upper gastrointestinal tract was x-rayed. These were reported as negative, and the patient was put on a salt-free diet.

Past history was essentially negative except for easy fatigue during the two previous summers which she attributed to the warm weather.

Examination on admission revealed a thin, dehydrated white female extremely restless and anxious. Blood pressure: 80/50; Pulse 96, thready; respirations 24, shallow. The skin was warm, dry, with a yellow-brown tinge. The sclera were clear. The abdomen was tender thruout and the bowel sounds were hyperactive. Pelvic examination was negative. The impression of the resident at this time was probable Addisonian crisis, precipitated by salt deprivation.

The patient was given 2 cc. of Cortate® (10 mgm.) and mild sedation along with 1,000 cc. 5% dextrose in water, 1,000 cc. 5% dextrose in saline, and 1,000 cc.'s Ringers lactate. Wangenstein suction was started and the patient was made comfortable for the night. The following morning, she was feeling better.

The laboratory workup on the morning after admission was not remarkable. RBC 4,180,000; Hb. 12 gms., 82%; WBC 6,500 with a normal differential. Blood sugar 78 mgm. %, CO_2 combining power 58 volume %; BUN 10.0 mgm. %; NPN 25 mgm. %; EKG: Essentially normal except for low voltage in the standard leads. Urines were essentially negative except for an occasional spilling of albumin. During the next few days, there was no change in the above laboratory values. The BMR on two occasions was within normal limits (-5%, -1%). The serum sodium two days after admission was 305 mgm. % (normal equals 315 to 340 mgm. %). The serum potassium was 23.3 mgm. %. (normal equals 16 to 22 mgm. %). On the fourth day after admission, the Robinson-Kepler-Power water test was done and revealed the following values:

$$\text{Formula} = \frac{\text{Urine urea N}}{\text{BUN}} \times \frac{\text{Plasma Chlorides}}{\text{Urine Chlorides}} \times \frac{\text{Vol. Largest Day Specimen}}{\text{Vol. Overnight Specimen}} = \text{Under 25} = \text{Diagnosis of Addison's Disease}$$

$$\text{Result in this patient} = \frac{435}{17.4} \times \frac{695}{36.8} \times \frac{50}{230} = 10.2$$

The patient was put on the following regime:
1) Cortate®, 3 cc. IM daily
2) Cortone®, 25 mgm. IM q.i.d.
3) Potassium free diet

The patient continued to show marked improvement

both objectively and subjectively. It was felt with the history and the physical findings: pigmentation, hypotension, response to medication, positive water test, that we could establish with reasonable certainty the diagnosis of Addison's disease.

The patient was discharged after one month hospitalization with marked clinical improvement. She continued on one cc. of Cortate® daily and ½ cc. of anterior pituitary extract every other day.

The crude anterior pituitary extract was given because it controlled her headaches, which occurred daily when it was withdrawn. To keep her in good condition it was necessary to give her Cortone 25 mgs. daily in addition to 25 mgs. of Cortate.

Blindness of Premature Infants

With Special Reference to Retrolental Fibroplasia

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Blindness in the premature infant in Illinois has become a major problem during the past fifteen years. The state is acquiring a large number of children who became blind in infancy. These children have have a special place in our society that at present cannot be too strongly stressed. They are blind from the beginning of life and expect to reach a ripe old age. During their whole liftime they must have education, training in special classes, care, and protection. Their parents or the state must furnish their means of survival. Because of lack of proper individual care and adaptability these children tend to become wards of the state and may be placed in institutions. Thus the parents, teachers, society, and the state are concerned with the blind infant.

In the past the most common causes of blindness in fancy were syphilis, gonorrhea, smallpox, trauma, and unknown congenital diseases. The compulsory instillation of silver nitrate and strict responsibility of the obstetrician have made gonorrheal ophthalmia of the newborn a minor problem of sight conversation. The epidemiological control of smallpox was one of the earliest methods which secondarily prevented loss of sight. The introduction of antibiotics and campaigns for the control of venereal disease have decreased the congenital blindness from syphilis and gonorrhea. In contrast to these known infectious diseases, the unknown congenital eye diseases have become more common. The greatest single cause of blindness in the infant is a widely spread disease, retrolental fibroplasia, that has only recently come into prominence by its rapidly increasing recognition. This disease is a bilateral exudative retinopathy of prematures. It is becoming the most outstanding eye disease causing lifelong blindness. In a 1948 survey of preschool blind children in the schools of 21 states, of the 2,500 blind children 1150 had retrolental fibroplasia. These statistics indicate that future prevention of blindness in infants lies in this wide field of congenital disease.

The customary practice of hospital pediatrics in the past was to discharge the premature infant without a careful eye examination. After the child arrived home, the mother discovered that the infant with retrolental fibroplasia showed signs of poor vision, the eyes turned in, or a pupil appeared partly or entirely white. The physician who was called later observed that vision was poor and ocular movements were without purpose. The irises were pushed forward, the lenses were clear, and there was a pinkish gray mass behind the lens. The next stage showed small eyeballs, sightless eyes, shrunken orbits, and semiclosed lids. The infant had blind mannerisms such as photophobia, a closed fist over eye, weaving of the body, and a tendency to strike the head repeatedly. Since retrolental fibroplasia is so prevalent now, the eyes of prematures are more closely observed in hospitals and the fundi are examined more frequently.

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The early active stages of the disease often are missed or not observed because they are best seen with the ophthalmoscope through dilated pupils. Such signs include tortuous and dilated blood vessels, neovascularization, retinal edema, vitreous haze, and retinal hemorrhage. This first phase is reversible. Later the retina may partly or entirely become detached. After the active stage, scarring occurs; masses and veils of scar tissue and retinal folds may be seen. In the severe disease, the mass of detached retina and scar tissue fill the space behind the lens. There are various degrees of activity and scarring. Vision may be normal after recovery or absent after detachment.

Many etiological factors that may have a bearing on the cause for the development of retrolental fibroplasia have been investigated. The following factors are not related to the disease: (1) age of the father or mother; (2) heredity; (3) time or place of conception; (4) time of birth; (5) epidemics in hospital, city, county or nation; (6) systemic diseases of the mother; (7) family; (8) economic or social status of family; (9) occupation of father or mother; (10) number of pregnancies or positional number of the pregnancy; (11) sex of infant; (12) disease causing premature delivery such as premature rupture of membranes, placenta previa, uterine bleeding, precipitant delivery, toxemia of pregnancy, and diabetes; (13) use of alcohol, tobacco, or sedatives by mother; (14) contraceptives; (15) use of drugs or anesthesia in delivery; (16) Rh factor; (17) developmental abnormalities of the infant; (18) action of light in the immature eyes of prematures; (19) postnatal infection of the infant; (20) vitamins or their vehicles ingested by the mother or child; (21) antibiotics or other drugs used for treatment of mother or child; (22) recent increase in survival rate of premature infants; and (23) cyanosis, jaundice, asphyxia of the newborn.

As far as it can be reasonably determined, the disease first appeared around 1937 in the U. S. where it was observed in mid-western and eastern states. The number of cases has increased rapidly since then. About 1947 retrolental fibroplasia was noticed in England and later in France, the Scandanavian countries, and Australia. So far it affects chiefly the white descendants of northern Europeans. It rarely develops in a negro infant although negro and white maternity centers have many prematures. The disease rarely occurs in fullterm infants but is more common in early prematures and in infants of multiple births. It tends to affect the more physiologically and chronologically early premature with the lowest birth weight and gestational age and the physiologically weaker twin or triplet. Although low birth weight is generally a useful and reliable measure of prematurity, low birth weight in itself is not necessarily a sign of prematurity in all infants. Infants have varied birth weights even at full term and negro babies are about 10 per cent less in birth weight than white infants, while in multiple births the weight is less than in single births. Furthermore, multiple pregnancy frequently causes premature delivery. It seems that the disease appears in infants who are less adaptive to their environment after delivery. Out of several thousand cases of severe retrolental fibroplasia, there are only about five instances where the abnormality has occurred twice in the same family; yet many mothers with one afflicted child have had premature infants before and after the affected child.

There are two questions which wait to be answered. Where was the disease before 1937 and why is it more prevalent in certain hospitals? There seems to be three possible answers; (1) a new drug came in use at that time, (2) a new virus or mutant of a common virus has caused a new disease; or (3) a change in the pediatric management has taken place. All of the drugs in the hospital records of several hundred cases of retrolental fibroplasia and many cases of normal prematures have been compared before and after 1937 in one hospital. Nothing of significance was found. Various tests such as serum protection tests, complement fixation, serum titers, and growth on chicken embryos that have been done on mother and infant to detect the presence of viruses and antigens have been valueless. Gamma globulin injections in the mother and child have not prevented retrolental fibroplasia. This leaves pediatric management.

Prediatrics has advanced rapidly in the past

twenty years, particularly since 1937. Many hospitals now have premature nurseries and an increasing number of prematures have survived through better care. Oxygen often is supplied in temperature controlled incubators in the nurseries. High concentrations of oxygen and long continued use have been mentioned as a possible cause of retrolental fibroplasia because more infants have the disease after a long period in oxygen than after a short time. A rapid change in oxygen concentration and lack of sufficient oxygen also have been considered. Still, many infants with and without added oxygen to their environment have developed retrolental fibroplasia. The common opinion of those who have investigated this factor is that oxygen concentration is not a primary cause but may be indirectly associated with the disease. But evidence is not conclusive.

The knowlege of metabolism of infants has broadened rapidly and the substitution of synthetic and modified food in place of human milk came in after 1935. Whether this change is related to retrolental fibroplasia is a question. In some hospitals, prematures fed only human milk never have the disease.

Until the end of 1949 incidence of retrolental fibroplasia in our hospital was high. Believing that the disease may be related to edema and vascular statis caused by disturbance of poorly controlled premature water and electrolyte metabolism, salt in the daily food intake was restricted so that it approached the concentration and amount of salt in human milk. In 1950, 1951, and 1952 only one infant annually developed retrolental fibroplasia. With this clew the investigation on this problem has continued because it appears to have a direct bearing on the disease.

There is no specific treatment for retrolental fibroplasia. In the early stages of venous dilatation, retinal edema, and serous exudation the disease may retrogress. If the retina is slightly or partly detached for a short time it may reattach with little damage to the eye but marked detachments lead to a loss of sight that may be relatively slight or total. The application of various ophthalmic solutions such as cortisone, miotics, and mydriatics to the conjunctiva have not proved useful. The addition of vitamin supplements to the diet of the infant has no effect. Vitamin E at one time was given as a preventive but many investigations have showen it has no demonstrable effect. Parenteral cortisone and ACTH have little influence on the course of the disease at any stage. Roentgen ray treatment is of questionable merit; its purpose is not to prevent or to cure but to hinded or change the course of events in the progress of the disease. There is no positive evidence that it does improve the end result. Surgical procedures for reduction of intraocular pressure, removal of the lens, section of the membranes of glial and connective tissue, and closure of the blood vessels in the vitreous are valueless and may add to the destructive process of the disease.

Since there is some positive evidence that a diet with an abnormal amount of salt may encourage retrolental fibroplasia, a diet approaching that of human milk is recommended. This must be left to the general practitioner or pediatrician. At present this is the only preventive that may be used. In the very early stages it may help to reverse the disease but the later stages are irreversible and incurable.

Society is interested in the life course of children with retrolental fibroplasia, whose vision ranges from 20/30 to total blindness. A few may widen their low vision with glasses. Since the eyesight is low before the child has developed maximal experience with his eyes, he is to be regarded as congenitally blind. The social approach to such a child is much different from that of a normal sighted child.

The parents are greatly depressed and disturbed when they realize they have a blind child and months pass before they can adjust themselves. A simple statement that the disease is not hereditary and is not caused by the father or mother often comforts them. The mother frequently becomes overprotective and sympathetic, particularly if it is the only child or she may ignore the child as a part of a guilt complex, and thus hinders mental and physical development so that the child is retarded and becomes a behavior problem. Some of these children end in institutions. Capable intelligent parents treat the child so far as possible as a normal child. Once a year many mothers of children with retrolental fibroplasia meet for a week at a state institution of Illinois

[Parents Institute for Preschool Blind Children] to discuss the disease and the blind child with an experienced staff of psychologists, teachers, ophthalmologists, and social workers. This plan is successful in preventing mental and physical retardation and in making the children more useful citizens by helping parents to adjust to the blind child.

Summary: Blindness in infants from infection and trauma has been reduced to a low level but congenital blindness is increasing rapidly. The most common cause is retrolental fibroplasia, which appears in the early months of life and frequently leads to blindness. The etiology may be related to the postnatal metabolism. There is no specific treatment.

The New in Dermatology

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The newer dermatology is an inevitable reflection of the amazing recent developments in all of medicine. The introduction of the various antibiotic agents and the steroids ACTH, cortisone and hydrocortisone, the advances in chemotherapy, the emphasis on the psyche in disease, the heightened tempo of graduate training etc., are all reflected in the dermatology of today.

Parasitic Diseases and Pyoderms.—Not long ago the pyoderms and the parasitic diseases such as scabies and pediculosis constituted a large proportion of dermatologic practice, particularly in dispensary practice. Today they are of negligible importance. The benzyl benzoate preparations and the proprietary products such as Kwell, Eurax, and Gamergent have not only simplified the treatment of scabies and pediculosis but they work more quickly and effectively than did the older treatment with sulfur. Usually a thorough bath and change into fresh bed clothes and but one or two applications of these drugs to all infected members of the family will eradicate the disease. It is only occasionally that the treatment has to be repeated.

The various pyoderms are also quickly eradicated today by treatment with antibiotic drugs. The superficial infections as impetigo, ecthyma, folliculitis etc. are readily cured by the application, at frequent intervals, of any of the newer chemotherapeutic or antibiotic ointments, the sulphonomides, penicillin, aureomycin, chloromycetin, terramycin, bacitracin, neomycin, erythromycin etc. All of them however are capable of inducing reactions of hypersensitivity in susceptible persons. We therefore suggest the employment of a drug such as bacitracin which is less likely to be used internally at a later time, and, because of the presence in pyoderms frequently of a combination of several different organisms, the preferred treatment is with an ointment containing a mixture of agents such as bacitracin with polymixin. For the deeper bacterial infections such as furuncle, carbuncle, deep seated pustular acne or hydradenitis suppurativa the internal administration of the antibiotic drugs, whether as the sole agent or as a complementary treatment to radiation or surgery is a distinct boon — seldom anymore, is vaccine therapy required.

Syphilis.—It is in the treatment of syphilis that the most amazing progress has occurred. It is no longer necessary to administer arsenicals and bismuth for many months and frequently to no avail. The modern treatment with penicillin is so effective that early syphilis is rapidly becoming a rare disease. The recommended dosage of 2,400,000 units of repository penicillin at the first treatment (one-half the amount in each buttock) followed by four injections at four day intervals of 600,000 units each, affects

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eminently satisfactory results and the practice of increasing the total amount of penicillin to 6 to 12 million units, over a longer period of time for older syphilis has also proved to be highly effective. It is an interesting commentary that but a few years ago, the diagnosis of syphilis presented but little difficulty — it was the treatment that posed a formidable problem. Today, because of the increased knowledge of the biologic, so-called false positive serologic reactions the situation is reversed. Effective treatment, has now been simplified but the diagnosis of a case often presents great difficulty. There is reason to believe that even this phase of the problem will be clarified by experience gained from greater use of the recently described treponema immobilzation test, which employes treponemal antibody distinct from reagin, an important development giving promise not only of more accurate diagnosis of syphilis but perhaps better insight into its immunology.

Mycotic Diseases.—The treatment of superficial mycotic infections of the skin still leaves much to be desired despite the steady introduction of new fungicidal agents each year. Little of great value has been introduced other than the salicylanilide compounds and the unsaturated fatty acids of the undecylinic proprionic type and even these, though they do have considerable worth, fall short of expectation. The results from their use were disappointing in the recent country-wide epidemic of ringworm of the scalp, a disease incidentally thought to be confined to children. We are now aware of a similar form of ringworm affecting the scalps of adults - an infection spreading out from the Southwestern part of the country. We can only hope that it will not become widespread, for the infection presents many difficulties - the clinical picture simulates, not the familiar child-type of ringworm of the scalp, but rather diseases as sebor rhoeic dermatitis or even lupus erythematosus; the involved hairs are non-fluorescent and agents available to us for topical therapy have so far been found wanting. Then too, the same non-fluorescent organism Tinea Tonsurans, is now infecting some children so that too much reliance should not be placed on the Woods light alone for the diagnosis of ringworm of the scalp even in children. Microscopic and culture studies are necessary.

The situation with regard to the deeper mycotic infections is a much happier one, for good results are constantly being reported from treatment with aromatic diamidines which have long been used for Leishmaniasis and other trypanosomiases. In-vitro studies with propamidine of this group of drugs were first reported on by Elston in 1945 and reports of three or four in-vivo trials appeared later, but it remained for Curtis to flood-light the treatment with dramatic effect by his report last year of successful treatment of four cases of blastomycosis that had previously been treated in vain with numerous other drugs. Two of his patients with cutaneous blastomycosis also had inoperable carcinoma of the prostate gland for which they received treatment with oral diethylstilbesterol. In both cases it was noted that the lesions of blastomycosis soon healed without "specific" treatment. Two other patients with systemic blastomycosis (without carcinoma) who had previously failed to respond to all manner of treatments were then treated with stilbamidene which is chemically related to diethylstilbesterol. The results were dramatic. Since then similarly good results have been observed in coccidiomycosis, nocardiosis and sporotrichosis. The drug, whose action though not fully understood, is obviously chemotherapeutic not hormonal, must be given with great caution by slow intravenous drip method and with the material freshly prepared in glucose solution at the time it is to be administered, because of the possibility otherwise of toxic hepatic and renal damage and in some cases delayed trigeminal neuropathy. The spectrum of effectiveness of this group of drugs, while at present narrow, appears to be widening so that there is hope that they may eventually be found useful in the treatment of superficial mycoses too.

Another new development in mycology is the suggestion to look for systemic causes for the recalcitrance of certain types of superficial fungus infections, particularly those due to T. Rubrum.

Steroids.—Hydrocortisone ointment has been available for general use for too brief a time to evaluate accurately its effectiveness. The few preliminary reports that have been published to date indicate a lack of agreement of its therapeutic value though it appears that hydrocortisone ointment may help to depress eczematous

lesions as long as the ointment is being used. Its cost is still prohibitive.

Experience with *ACTH and cortisone* however is now sufficient to warrant a rather precise assessment of its place in dermatology. The drugs have assets, limitations and liabilities. They depress activity of disease processes without greatly altering the natural history of the disease so that their greatest value in dermatology is for diseases such as drug eruptions, erythema multiforme, erythema nodosum, and poison ivy dermatitis in which the etiologic factor is no longer in effect. In such cases the drug need be administered for only a short period of time thus avoiding the unwanted changes that result from cumulative dosage. The corticoids, even though they merely depress symptoms and do not effect cures, have been instrumental in prolonging the lives of patients with pemphigus, acute systemic lupus erythematosus, and exfoliative dermatitis. Some cases of alopecia totalis are benefited but for only as long as the drug is administered. Acute lichen planus is also benefited but results are disappointing in psoriasis, atopic eczema, anogenital pruritus, contact dermatitis of obscure cause, nummular eczema, seborrhoeic dermatitis and similar common but troublesome diseases. If the steroids are to be used for such diseases they should be used only when heroic measures are needed to give comfort as for psoriatic or eczematous cripples, those with such acute or wide spread lesions that they cannot work, move, or relax.

Lupus Erythematosus. — Though dermatologists have been studying and discussing this disease for about one hundred years it is only recently that the profession at large has shown interest in it. This is due partly because of the discovery of the L E phenomenon, partly because of the intensified study of the pathology of the disease, and partly because of the newer and better treatments that are now available for both the systemic and discoid varieties of the disease. The L E phenomenon consists of clumped leukocytes followed by the appearance of inclusion bodies in some of the cells when blood from a patient with systemic lupus erythematosus is added to normal blood or marrow. It is considered to be pathognomonic of systemic lupus erythematosus— not the discoid variety, and it has helped to clarify to a certain extent a syndrome with many puzzling features. The demonstration that treatment with the corticoids, ACTH and cortisone would suppress symptoms and prolong the life of the patients with systemic lupus erythematosus is also responsible for the heightened interest in the disease.

The *discoid* variety of *chronic lupus erythematosus,* while not as serious a disease as the systemic variety, has always constituted a therapeutic problem to dermatologists. A number of remedies, chiefly the heavy metals, solid carbon dioxide, and liver extract, have affected a certain degree of improvement in the lesions but seldom are the results completely satisfactory. Recently there have been good reports from treatment with Atabrine. The drug was apparently first employed in Russia some thirteen years ago, but it is only in the past year that it has had extensive trial in this country. The initial reports all have a favorable tone. The optimium dosage and treatment schedules have not yet been determined but the usual procedure is to administer 300 mg daily for the first week 200 mg daily for the second week and then 100 mg daily. The drug causes the patients to turn yellow in time, and not all of them benefit from the treatment. Atabrine is a drug to be employed with extreme caution because of its tendency to provoke untoward, some times serious, reactions in the hepatic renal, hematopoetic, nervous and cutaneous systems. A rationale for the treatment has not yet been suggested. Yet in general, the results from treatment with atabrine are such as to warrant further study of it.

Hair. — Knowledge of the development cycle of a hair follicle and of the regeneration rate and growth of human hair has been enchanced considerably in recent years. Of special interest are the recent laboratory investigations by Flesch of the temporary depilatory effect of certain naturally occurring compounds. They may open a new course for the study of baldness and perhaps suggest a chemical clue to the etiology. This study developed from the observation several years ago that workers in the synthetic rubber industry who used neoprene became temporarily bald. The hair-fall subsequently was traced to a group of intermediary polymers or dimers and one of them, chloroprene, when applied to the skin of laboratory animals, not only caused complete loss of hair but also caused

disappearance of hair-follicles, keratinization and in vitro it inactivated sulfhydryl groups of chemicals. The theory then was advanced that other unsaturated compounds might effect similar changes. Vitamin A, a polymer of isoprene related to chloroprene, then was studied in a similar manner and was shown also to effect keratinization and cause generalized loss of hair in both animals and humans. It was found to produce a local depilatory effect but, unlike chloroprene, it did not inactivate sulfhydryl compound in vitro. Among other compounds studied was one named "squalene," an unsaturated hydrocarbon constituent of human sebum. It was found that a single application of squalene caused reversible local depilation in rabbits and guinea pigs but not in mice and, like chloroprene, it inactivated free sufhydryl groups in vitro. It did not affect keratinization or cause disappearance of hairfollicles. It was suggested therefore, that squalene or a related unsaturated compound in sebum might influence the growth of human hair, a suggestion that does not negate the long-held view that endocrines influence baldness, for endocrine substances (especially male hormones) do have a stimulating effect upon sebum.

Pigment. — Considerable interest has been aroused by the report from Egypt of a successful treatment for vitiligo. The drugs used, crystalline compounds named "ammoidin" and 'ammidin', are isolated from the fruits of the plant ammi majus Linn which grows abundantly in the Nile delta and in places in French soil. In fact, since the thirteenth century the Egyptians have used a powder prepared from the fruit of this plant for the treatment of leucoderma but it provoked a high incidence of disturbing gastrointestinal reactions and occasionally even nephritis and coma. The active principles, ammoidin, and ammidin were isolated in 1947-49. They are prepared in tablet form for oral administration and as an alcoholic paint for topical application. The combined treatment is used in most cases and the results are said to be enhanced when the crude plant preparations containing majudin are used. The preparation must be administered intermittently for several months, the application of the alcoholic paint being followed by ultraviolet irradiation. In a few days there are produced erythema and vesiculation which are followed by the production of pigment at the periphery of the patches. Improvement occurs more quickly in lesions on the trunk than in those in extremities. Apparently in some cases it produces satisfactory results for as long as the drug is used, but not complete cures. The mechanism of action of the drugs has not yet been determined and there has not been sufficient experience with the treatment in this country to warrant an estimate of its value. It is likely that the drugs will be identified as a derivative of furo-coumarins called psoralens which should not be used in the presence of hepatic insufficiency or diabetes mellitus.

Hyperpigmentation, due to deposits of melanen in the skin, can now be depigmented to a satisfactory degree by the application to the patches of an ointment containing monobenzyl ether of hydroquinone. This drug must be used with great caution for the incidence of eczematous reactions produced by it is very high.

Protective Agents. — There has long been need for an effective agent to protect the hands of workers from irritation from soaps and other chemicals. The need is even greater now since the increased use of the newer often irritating detergent agents used by the housewife. Protective agents hitherto available have usually been found wanting because of their solubility in water. Recently creams containing silcone have been introduced to act as a protective barfor silicone creams are protective agents not rier and in many cases they are effective provided they are applied to skin that is free of dermatitis, curative.

The above is but a part of the new in dermatology. Research in fundamental phases of the subject has given newer insight into the important functions of the sebaceous glands, hair and pigment and has led to better and more rational therapy for diseases affecting these structures. The way has been opened for a new approach to the differentiation of amelonotic melanomas from other lesions which it simulates. The derivatives of isonicotinic acid are being used for tuberculoderms; hormones, vitamines, antihistaminic agents and newer vehicles for drugs are also be-

ing studied and even psychiatric investigations of patients with various dermatoses are being carried out intensively and earnestly even though thus far in most cases the investigations may indicate why a patient has the dermatosis, but it much less often helps the patient to be rid of it.

104 South Michigan Avenue

FACTORS LEADING TO TOXEMIA

The borderline between the physiologic changes of pregnancy and the pathologic changes of toxemia is found to be narrow, but thus far no one has been able to indicate what is the precipitating factor which turns the course from normal to abnormal. There are, however, serveral well-recognized conditions which are associated with the incidence of the preeclamptic state:

1. Toxemia of pregnancy is far more likely to occur where there has been pre-existing vascular hypertension.

2. The patient who gains weight rapidly and excessively during pregnancy and shows a tendency to water retention is a susceptible subject for toxemia.

3. There is a well-recognized difference between the frequency of occurrence of toxemia among cooperative, economically favored patients and among those whose socio-economic situations make it difficult for them to grasp the importance of or benefit from the usual measures of prenatal care. Just why this difference exists has not been definitely determined, but it is quite probable that the greater stress and strains of life, poor living conditions, and gross inadequacies of diet, particularly as regards the consumption of first-class proteins and vitamins, account for it.

4. There is a known racial difference between the frequency of toxemia of pregnancy in colored and white women. This is in part attributable to the socio-economic factors which have been mentioned and in part to the increased frequency of vascular disease and hypertension in the colored.

5. The obstetric complications — multiple pregnancy, polyhydrannios hydatidiform mole, and also primigravidity — are known to contribute to the frequency of toxemia of pregnancy. Some investigators are of the opinion that overdistention of the uterus by the conditions named affect in some simple fashion the development and physiology of the placenta and lead to the injection of toxic products or thromboplastin into the maternal system in excessive amounts. *Thaddeus L. Montgomery, M.D. Preventive Measures Against Toxemia of Pregnancy. Pa. M. J. June,* 1953.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Splenectomy in Sarcoidosis

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Sarcoidosis is a chronic generalized disease of unknown etiology. Involvement of nearly every organ in the body has been described. The more common sites, in order of frequency, are lymph nodes, lung, liver, spleen, heart, kidney, pancreas, and bone marrow. The less common sites are brain, meninges, skin, eye, tonsil, antrum, pleura, prostate, testes, epididymis, seminal vesicle, thyroid, parathyroid, pituitary, skeletal muscle, small intestine and adventitia of the great vessels.

The basic lesions are gray or yelow granules which may be scattered or closely packed into tumor-like masses. They may be limited to one or another organ or scattered throughout the body. The lesions are not encapsulated, but are sharply demarcated, and show no necrosis or caseation. Microscopically the lesions are uniform in appearence throughout the body. These nodules or tubercles consist of collections of epithelioid cells with frequent giant cells, and occasional lymphocytes and plasma cells. The lesion is characteristic of a low grade interstitial granulomatous inflammatory process occurring in multiple foci and suggesting a response to some unknown causative agent which is disseminated by way of the blood stream. Healing is by slow fibrosis. The effects upon the body depend upon the location of the lesions, their size, and on the presence of secondary infection. The disease is non-toxic but its manifestations are produced by mechanical interference with the function of invaded organs.

The early investigators recognized the similarity of the lesion to tuberculosis and considered the disease "tuberculoid". Besnier in 1889 described a disease with large plaques on the face and changes in the small bones of the hands which he called lupus pernio. Caesar Boeck in 1899 described a similar condition as multiple benign sarcoid of the skin, and later called it benign miliary lupoid. Schaumann in 1914 was the first to recognize the various lesions as manifestations of the same generalized

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disease. The concept that sarcoidosis is a variety of tuberculosis is unproven. Pinner favors this view while Michaelson opposes it. The disease appears to be a specific granuloma of uncertain origin. Freiman discussed all the theories concerning this disease in an interesting paper on the subject.

M. R. a 39 year old negress was first admitted to Cook County Hospital on May 5, 1952 with a history of fatigue and migratory joint pains of one year duration. She was treated for "arthritis" and was told she had a "lump in her side". There was an eleven pound weight loss during the three months prior to admission. In addition, an intermittent, aching, left upper abdominal pain became gradually more severe. Fever was occasionally noted. A productive cough with blood streaking developed. The past history was essentially negative. Her father died of tuberculosis when the patient was six years old. She was born and reared in Mississippi and came to Chicago in 1943.

Physical examination showed a well developed, well nourished female, not appearing ill; BP 100/70, P 60, R 18, T 99.6°F.; bilateral anterior and posterior cervical, axillary and inguinal lymphadenopathy. There was slight enlargement of the tonsils. The inferior border of the liver was palpated three fingers below the right costal margin in the midelavicular line. The spleen was enlarged with the inferior edge at the level of the umbilicus. Biopsy of a posterior cervical lymph node on May 9, 1952 revealed "Boeck's Sarcoid". Sternal marrow showed an abnormal non-specific cellular pattern.

Chest x-ray showed accentuation of hilar markings suggestive of lymphadenopathy. Old tuberculin skin test 1:1000 was negative. X-rays of the hands and feet showed cyst-like areas in the base of the middle phalanx of the third right finger and head of the fifth left metatarsal. Examination of the eyes was essentially negative. The patient was discharged and followed in the out-patient clinic.

She was readmitted to CCH on March 11, 1953. Since her previous admission abdominal pain, weakness and malaise had persisted with occasional bouts of fever. The spleen had continued to enlarge. Three months prior to this second admission, skin lesions were first noticed on the right cheek. They subsequently developed on the arms, neck, eyelids, forehead and back. The cough had improved although hemoptysis had occasionally occurred. Physical examination at this time showed a chronically ill, very thin woman with enlarged lacrimal glands, a mucus patch in the mouth, "Psoriatic-like" skin lesions with scaling centers and subcutaneous nodules of the face, temples, neck, knees, and back. Generalized lymphadenopathy was present. A systolic murmur was noted at the apex. The liver was enlarged to seven centimeters below the costal margin; the spleen was enlarged and could be felt at the iliac crest. X-rays of the chest, hands, feet, legs, arms and skull were negative except for cyst-like changes of the hands and feet and hilar lymphadenopathy of the lungs

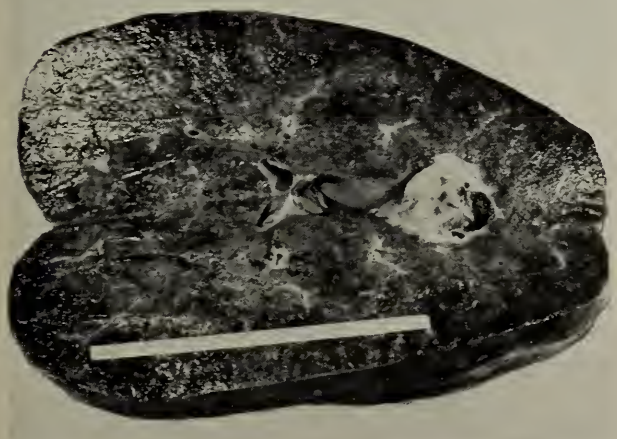


Figure 1. The spleen measured 30 x 20 x 10 cm. It was firm and the cut surface showed numerous small gray mottled areas.

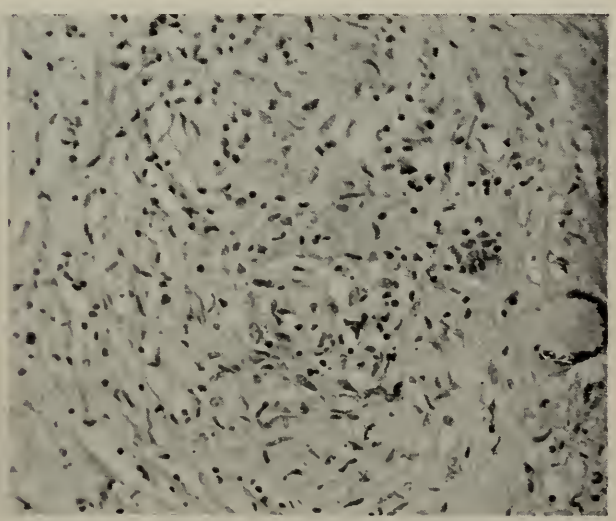


Figure 2. Cytology in high power view of tissue.

bilaterally. The bone marrow was suggestive of hypersplenism. Splenic aspiration on March 28, 1953 failed to show any specific change.

After several blood transfusions to correct the anemia, splenectomy was done on April 25, 1953, to correct hypersplenism and the obvious mechanical disadvantages of the massively enlarged organ.

The specimen (Figure 1) measured 30 x 20 x 10 Cm. and weighed 1200 Gms. when freed of blood. The consistency was firm. The capsule was thickened with irregular gray mottling. The cut surface showed numerous small gray mottled areas. Microscopic section showed the typical lesions of sarcoidosis (Figure 2).

Laboratory findings:

	5/6/52	3/12/53	4/17/53	4/24/53(pre-op)	4/30/53(post-op)
Urine	neg.	neg.	neg.		
Hbg:	71%	45%	54%	66%	74%
RBC:	4,560,000	3,100,000	2,820,000	4,110,000	
WBC:	6,200	5,400	3,650	6,000	2,250
Neut:	64%	52			
Band:	21%	8			
Eos:		2			
Lymph:	4%	23			
Mono:	10%	15			
Platlets:			600,000		
Kahn:	neg.	neg.			
NPN:	30 mg%	30			
TP:	8.1 gm%	7.5	9.4		
Alb:	3.0 gm%		3.3		
Glob:	5.1 gm%		6.1		
Alk. Phos:	2.1 Bodansky U.	3	3.8		
Ceph. Floc:	3 plus	2 plus	3 plus		
Thymol Turb:	10.4 U.	9.2	7.2		
Gamma Glob:	3.8 gm%	4.56	3.60		
Prothrombin:		57%			
EKG:		within normal limits			

The patient made an uneventful post-operative recovery and was discharged on May 6, 1953 with marked symptomatic relief from abdominal distress. When seen in the out patient clinic she continued to be free from symptoms.

DISCUSSION

Sarcoidosis is probably common. It has been reported throughout the world. Negroes are particularly susceptible and make up 73.4% of 523 cases reported in this country. The young are usually affected at an average age of 20 to 40 years. The sexes are equally susceptible. The disease is benign in nature with a multiplicity of symptoms and signs, and with numerous regressions and exacerbations.

The onset is insidious. The most common complaints are ocular disturbances (even though the eye is less commonly involved), enlarged lymph nodes, weight loss, fatigue, malaise, cough, skin eruption, shortness of breath, and anorexia. Occasionally patients with the disease are found with extensive involvement but without symptoms.

Lymphadenopathy is frequent in occurrence and may be generalized, symmetrical, regional, or local. Lung involvement is the most common among the internal organs. Roentgenographic changes may be of a miliary type; linear, fan-like extensions from the hilum; nodular infiltration; diffuse and confluent infiltration; or, pulmonary and mediastinal lymphadenopathy. These lesions may clear completely, recur, or fibrose, and may cause emphysema, bronchiectasis, segmental collapse, pleural effusion, fatal pulmonary hemorrhage, pneumothorax, pleuritis, cavitation, and cor pulmonale. The heart may be directly invaded or damaged indirectly from pulmonary involvement with development of cor pulmonale. Heart block, arrhythmias, cardiomegaly heart failure and sudden death may occur.

The alimentary tract is only rarely involved. The genito urinary tract is frequently damaged, but whether sarcoidosis is capable of causing death through renal impairment is not known.

Lesions in almost all of the endocrine glands have been seen but the adrenal is rarely, if ever, affected. Evidence of impairment of function of any of these glands due to invasion has not been found except for several instances of pituitary insufficiency which have been reported. Central as well as peripheral nervous system involvement is occasionally seen. This has resulted in transient paresis and paralysis, and in some severe neurological signs with convulsion and death.

Ocular sarcoidosis forms one of the triad of cardinal signs in uveoparotid fever, and is quite frequent. It may invade only the lacrimal glands but occasionally it has caused optic atrophy or complete destruction of the eye. Uveoparotid fever is now known to be only a manifestion of this generalized disease. It is associated with fever, uveitis, swelling of the parotid glands and facial palsy.

Cutaneous lesions are common. They may consist of nodules, conglomerate masses or large plaques. They may occur anywhere on the body. However, the face, eyelids, nose, ears, shoulders and upper extremities are the most frequent locations. Bone involvement is not too frequent. When seen it usually affects the hands and feet, although extensive changes in other portions of the skeleton do occur.

The liver is one of the most common sites for the lesions as has been shown by autopsy, laparatomy, and needle biopsy. However, clinical evidence of invasion except for hepatomegaly is rare. Cirrhosis has been seen associated with extensive involvement, especially, in the periportal areas.

The spleen, along with the liver is second only to lymph nodes and lungs in frequency of involvement by this disease. The organ is usually enlarged and may be massive in size. However, extensive lesions are often found when the size of the spleen is normal. In cases with extremely large spleens, complaints of dragging sensation or abdominal pain are often noted and may be explained on a mechanical basis as in the case reported here. Pancytopenia, gastric hemorrhage, cirrhosis, portal hypertension, ascites, and rupture of the spleen have also been reported. Several instances with and without splenomegaly have been discovered only after splenectomy and histological examination of the spleen in patients in whom the disease was unsuspected preoperatively. The red blood cell, white blood cell and platlet counts all improved or returned to normal. However, except in patients with very large spleens, removal of the organ seemed to have little effect on the general course of the disease. Sarcoidosis of the spleen alone does not occur. It is always in association with the generalized disease.

Sarcoidosis is a disease of few symptoms when the extent of the pathological process is considered. Generally, anemia or leucocytosis is unusual although leucopenia frequently is associated with splenomegaly. Thrombocytopenia may occur. Bone marrow studies have occasionally shown sarcoids. Hypercalcemia, hyperglobulinemia, and high serum alkaline phosphatase levels are unexplained findings.

The course of this disease is variable and unpredictable. The absolute diagnosis is dependent upon biopsy and the finding of typical microscopic lesions. The epidemiology is obscure. The disease may be mild or severe; it may remain unchanged for years, or go on to slow or rapid clearing, or it may end in death.

The treatment in the past has been very unsatisfactory. Arsenic, ultraviolet light, calciferol, antibiotics, nitrogen mustard, and urethane have all been tried with little success. Recently ACTH and Cortisone have brought about some dramatic improvements in several patients. They are at present undergoing extensive trial and appear to have a great deal to offer in the treatment of this disease.

SUMMARY

A brief review of sarcoidosis with a case report showing many common as well as unusual characteristics of the disease is presented. Splenectomy is indicated for symptomatic relief when a large spleen is associated with the condition.

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EDITORIALS



Rx SUBSTITUTIONS

Last year one of the leading pharmaceutical journals, American Druggist, made an industry-wide survey of the drug substitutions — that is, the dispensing of a drug or brand of drug other than the one specified in the prescription. The pharmaceutical manufacturers hired investigative agencies to shop around various drug stories and they found substitutions on some products ranging as high as 25 per cent. In nine out of 10 such cases the substitutions consisted of replacements with direct, unmistakable counterfeits rather than with other brands. These counterfeits came from unknown, fly-by-night manufacturers who are able to undersell reputable manufacturers because they have no research or physician-promotion costs; nor do they have a reputation to protect. According to the report, one operator "offered to druggists a printed list of 97 products, each labeled with a proper, although completely unknown, trademark." Salesmen contact druggists and pencil in the name of a well known legitimate product for which the phony item is to be substituted. The counterfeits "are made to look exactly like the originals in size, color, scoring, and embossing." Almost 65 per cent of the ethical pharmaceutical manufacturers considered the problem so serious they adopted special programs to curb the practice.

One of the highlights of the survey was that the manufacturers believed that "greed on the part of unscrupulous pharmacists" was the main reason for such substitutions. The retailers blamed duplications. There was disagreement on the means of correcting the practice; 29.3 per cent of the manufacturers thought more vigorous action ought to be taken against the culprits by state pharmacy boards. A smaller percentage (20.6) believed an educational program is in order to show retailers that substitution is unethical and endangers the profession of pharmacy. On the other hand, 71.4 per cent of the retailers favored curtailment of the practice of duplicating specialties already on the market; and 32.8 per cent suggested that physicians be educated to use generic rather than brand names in writing prescriptions. Others were of the opinion that the pharmacist ought to be allowed to use his own judgment in selecting alternate brands when he does not have on hand the brand specified in the prescription. A reduction in prices of specialties also was recommended.

It is refreshing for the medical profession to be on the sidelines watching others wash their dirty linen. As with physicians, however, only three per cent of all druggists undermine their profession. Fear of substitutions will convince many physicians that they should dispense their own medicines. The remainder must urge their patients to have prescriptions filled at drug stores known to be ethical and honest.

There are two sides to every question and many

physicians will agree with druggists on the problem of duplication. It is becoming harder and harder for the physician to remember the brand names of all of the more common drugs on the market. On the other hand, we are all for free enterprise and in this respect, our pharmaceutical houses have a right to manufacture any number of drugs that are efficient and safe.

OUTSTANDING GENERAL PRACTITIONER FOR 1954
George Allen Dicus, M.D., Streator

George Allen Dicus, Streator (LaSalle County) was selected the outstanding general practitioner in Illinois for 1954. His name will be submitted to the American Medical Association at its Clinical Session in St. Louis December 1-4, as a candidate for the national honor.

Doctor Dicus is ninety years old, still practicing medicine and surgery, still driving his own car on house calls, and still actively interested in postgraduate education in his chosen profession.

A secret committee appointed by the President of the Illinois State Medical Society met and considered material submitted in behalf of candidates from various counties throughout the state, and by unanimous vote, selected Doctor Dicus for the 1954 honor. He will be presented a certificate at the first meeting of the House of Delegates to be held at the Hotel Sherman during the annual meeting of the Society in May.

On his 90th birthday, last August 12, the Streator Kiwanis Club held a special city wide celebration in his honor, for which the whole town and the surrounding territory "turned out". Doctor Dicus was born in Moscow, Ohio, August 12, 1863, was graduated from Rush Medical College in 1889, studied for a year in Europe (under vonBergman, and Virchow), then returned to practice medicine in Streator, in 1891.

Twelve years ago he was given membership in the Fifty Year Club. During the past 53 years, Doctor Dicus has served as secretary of the North Central Illinois Medical Society. He served as a Captain in the Medical corps of the Army during World War I, and still holds a reserve commission, retired.

Doctor Dicus is the fifth Illinois physician selected outstanding general practitioner. In order of their election, we have honored, Dr. Lee T. Hoyt of Roseville, Dr. Andy Hall of Mt. Vernon, Dr. E. E. Davis of Avon, Dr. J. B. Schreiter of Savanna and Dr. James S. Templeton of Pinckneyville. We are proud to add Doctor Dicus' name to this list for 1954.

NUTRITIONAL AND WEIGHT CONTROL PROGRAM

A pilot nutrition and weight control project is to be conducted during the winter of 1954 in Winnebago County (Rockford) Illinois. A great deal of effort and planning has gone into the work. This is a cooperative project sponsored by the Illinois State Medical Society, the Illinois State Department of Public Health, the Illinois Heart Association, and the Home Economics Extension Service of the University of Illinois. Local sponsorship has been joint and includes the Winnebago County Medical Society, the Winnebago County Heart Association, the Council of Social Agencies and the Winnebago Home Bureau. The project is designed as a community service. The general plan was presented to the Winnebago County Medical Society in preliminary form in May 1953 and again October 9, 1953. Overwhelming approval was given to the project.

It is planned to have eight weekly meetings. People will be admitted to the course only on recommendation and approval of their physician and the physician will specify how much weight he feels that his patient should lose during the course of the classes. The lessons are based upon the scientific contributions of the physician and nutritionist. The presentation is made even more attractive by the skill of the Home Extension specialist. Over the years the extension workers have developed procedures for presenting factual material in a way that is interesting to and retained by the lay person.

Previous campaigns of this character have been conducted in various places, notably in the state of Indiana and the city of Louisville, Kentucky. They have generated much wider public support for the voluntary health agencies. This program presents an opportunity for the profession to display interest in health education for the community. It will lead to increased awareness of the major problem of obesity and will be of benefit to everyone concerned.



George Allen Dicus, M.D.

NARCOTIC CLINICS IN ILLINOIS

Illinois now has three medical counseling clinics in Chicago for narcotics addicts, the last having been opened at Northwestern University Medical Center late in 1952. The other two clinics, which began operation approximately a year earlier, are located at Provident Hospital and at the Research and Educationl Hospital of the University of Illinois.

The establishment of these clinics is the direct result of dynamic action by a community aroused because of an apparent increase in drug addiction among teenage groups and young adults. Brought to the attention of the General Assembly in 1951, a law was passed providing for the creation of the clinics together with an appropriation to cover cost of operation. The State Department of Public Health was charged with the responsibility of carrying out the provisions of the law.

The various types of activities carried on by these clinics are designed to implement the broad goals of prevention, treatment and rehabilitation of narcotics addicts. The services of psychiatrists, clinical psychologists and social workers are available to clinic patients. Medical consultation is provided when indicated.

To avoid duplication of effort and to explore all possibilities for the clinics, three separate approaches are being tried. The University of Illinois clinic is studying the pre-addiction problem and is primarily concerned with the young addict under 21 years of age. The clinic at Provident Hospital works with the general drug addict to determine the value of medical counseling, follow-up and rehabilitation. Northwestern University clinic, in working with the neurotic type, is attempting to learn if the addict may be benefitted by regular psychotherapy on an out-patient basis.

Research activities are carried on by each clinic. Among others, studies are being made to determine the relationship of drug addiction to malnutrition, organization of the patient's family and the local community.

Some 400 drug addicts had been officially admitted to these clinics up to June 30, 1953. A large percentage were under 30 years of age, with a preponderance of male to female and negro to white patients.

As to educational background, most of the patients had attended high school but few had any college training. A majority of the addicts fell into the classification of semi-skilled or unskilled laborers.

Many of the patients entered the clinics on their own initiative. A smaller number were referred by the courts, particularly the Narcotics Court, and by social agencies.

Unfortunately, a large majority of the patients were currently addicted and in need of immediate hospitalization. All too few were in the pre-addiction stage, when the clinics found them most responsive to extended treatment.

Although it is too early to form any definite conclusions as to the work of these clinics, they appear to be rendering a valuable service in guiding currently addicted persons to sources of treatment and in the follow-up and rehabilitation of addicts after treatment. The clinics are also serving as a nucleus for much educational activity.

As activities of the clinics expand it is conceivable that preventive techniques such as applied mental hygiene among pre-addiction susceptibles or general youth groups may be the most effective phase of this work. There is already some evidence that deep addiction may be prevented in teen-agers in the "reefer" smoking stage when stronger drugs are used only occasionally.

So it appears that in drug addiction, as in many other public health problems, "an ounce of prevention is worth a pound of cure."

AT LAST!

The x-ray table is one of the most uncomfortable pieces of equipment in the office and hospital. It is hard, often cold and patients complain, especially the thin, the elderly, and those wearing the typical open back hospital gown.

Orloff[1] solved the problem with a latex foam pad. He found that a No. 4 size pad, 24" x 60" x ½" was suitable. This was covered with a "supported back plastic" prepared from virgin vinyl resin that did not stretch nor react chemically with latex. Muslin was used as backing for the vinyl plastic. A cover was found necessary

1. Orloff, Theodore L.: Latex Foam Padding for X-Ray Tables. Journal of the Albert Einstein Medical Center, August, 1953.

because an uncovered pad becomes saturated with opaque particles. The pad and covering did not interfere with the roentgenographic image.

The cover is lightly stitched in place except for a section on one side where a zipper is inserted. Muslin strips are sewn into the edge of the plastic cover to fasten the pad to the table. One of these pads has been used for six months and many of the patients have acknowledged their appreciation for the added comfort.

REPORT OF THE JOINT COMMITTEE ON CHEST X-RAY*

Purpose of Joint Committee on Diseases of the Chest

In establishing a Joint Committee on Diseases of the Chest, the purpose of the American College of Chest Physicians and the American College of Radiology is the exchange ideas and to propose guiding principles on the problems involved in routine chest x-rays in hospitals (general, mental, etc.), and mass chest x-ray programs. The committee agrees: that each physician should be encouraged to have a chest x-ray of all of his patients; that every patient admitted to a hospital private or public, should have a routine chest x-ray; and that the follow-up for all suspected lesions seen in chest x-ray surveys should be organized very carefully to assure that patient comes under medical supervision.

Limits of Survey

Routine chest x-ray examinations should be defined as those examinations of the chest which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The examinations are screening diagnostic procedures and are not to be considered as clinical diagnostic examinations. The screening method is for the purpose of detecting the presence or absence of a lesion only.

The size of the film which one uses for screening purposes is not of primary importance. The committee believes in principle, however, that when microfilms have been used, a 14 x 17 inch film is a necessary second step in the screening procedure and the mechanism whereby such is provided in any community shall be determined by the local medical society or the local hospital staff. Survey chest x-rays either in hospitals or in the general population are approved as a screening device if conducted by agencies which utilize well qualified professional and technical personnel and which make sincere efforts to send the positive individuals to qualified local physicians or clinics for proper follow-up.

Interpretation and Report

Interpretation and reporting of medical findings is a medical matter and should bear the signature or identification of the responsible physician.

Method of Reporting

Method of reporting of chest survey studies: This is a local matter and is by prearranged agreement between the employer and the employee in industrial surveys; in other surveys it is in accord with medical ethics, according to local agreement.

Type of Reporting

Type of reporting: The Committee discourages the reporting of suspicious cases as tuberculosis. It believes this to be clinical diagnosis. The x-ray interpreter should designate the cases that require immediate follow-up as "urgent". The small film x-ray interpretation is merely an impression.

It should be emphasized that the 14 x 17 inch film is a diagnostic aid and the results derived therefrom are also impressions and not diagnoses. Even the larger film is but one of several examinations necessary in order to establish correct diagnoses.

Double Reading

The committee notes the several publications indicating the extent of false negative and false positive reports resulting from inter- and intra-individual variations in interpretations of chest films. From these it is evident that failures to detect tuberculosis can be reduced by multiple readings, but at the expense of increasing the false positives, unless a check mechanism is employed. The simplest elaboration of multiple reading is the independent interpretation of the film by two physicians with referee conference of the two undertaken in those cases in which they disagree. Only those cases on which both agree in conference should be followed.

While such a procedure may result in the detection of a slightly larger portion of all the

*Approved by Joint Committee on Chest X-ray; American College of Radiology, American College of Chest Physicians, February 4, 1953.

abnormal cases, it may not be feasible from an economic or personnel standpoint. Groups responsible for survey operations are urged by the committee to give consideration to double reading as one of the methods by which survey yields may be increased. Availability of financial resources and qualified professional personnel, as well as the need for other services of relative importance, will be determinates in this decision. The committee, therefore, calls attention to some of the virtues of double reading but does not recommend it unreservedly.

Professional Compensation

The professional cost of performing routine chest examinations in hospitals: The Joint Committee believes the radiologist and/or chest physician should be compensated just as any other physicians practicing his profession. The procedure is time consuming and places a definite responsibility on the radiologist or chest physician. The Committee likewise felt that in this matter the basic principle of payment is by arrangement between the physician and the hospital or agency involved. In the reading of follow-up films there should also be an individual limit to the number of films which should be read in any one day by one physician and which he should not exceed. The compensation, of course, would have to take into consideration, whether the physician makes the film in addition to interpreting it.

Clothing of Patients

Whether or not a screening examination can be conducted with the patient fully clothed: Since the number of lesions overlooked because of clothing (2 per cent) is considerably smaller than the normal variations of interpretation (Chamberlin, etc.) have demonstrated to exist in the reading of photofluorographic films, it is concluded that the examination of clothed persons is as effective a procedure as examination of the undressed persons. Since examination of the fully clothed persons is an easier procedure as compared with the examination of the undressed persons, the Committee agreed that screening examination may be conducted with the patient fully clothed.

Reader's Qualifications

Qualifications of readers in mass chest surveys: It was believed at the present time there was no practical method which could be used to evaluate the qualifications of a particular reader. Studies in this respect re being made at the present time. It is hoped that within a short period of time satisfactory testing methods will be available The committee therefore agreed to leave this matter open for further discussion.

Protection

The radiation received by all professional, technical and clerical personnel associated with photofluorographic equipment should be continuously monitored by means of film badges or other devices which have been proved to be satisfactory for determining the radiation exposure of personnel.

When an individual receives more than 100 milliroentgens per week, the medical officer in charge of the unit should immediately determine whether the individual has been careless or whether the protective devices of the equipment are at fault.

If the fault lies with the individual, the individual should be informed of the fact and strongly cautioned regarding the dangers of excessive radiation exposure. Failure to regard such warning should be considered as negligence on the part of the individual.

If the fault lies with the equipment or protective devices, the photofluorographic unit should immediately be taken out of commission until such time that measurements of radiation conditions where technical or clerical personnel are required to work will yield radiation exposures less than 100 milliroentgens per week for case loads of 2,500 exposures at 95 kv. and 40 ma. seconds (the average exposure per photofluorographic chest film).

Continuation of Study

It is recommended that the Joint Committee arrangement continue and that the Joint Committee meet annually, or at the call of the co-chairmen. In an effort to have the Joint Committee act continuously and without interruption, interim ideas should be sent to the co-chairmen, and an exchange of opinion should continue during the intervals between meetings. Recommendations are solicited from all interested in the affairs of the Joint Committee.

THE DOCTOR AND THE "GOOD EARTH"

Dr. David J. Davis,
Permanent Historian,
Illinois State Medical Society

It was not difficult for the ancients to learn that the earth is good. They knew that from the upper few feet of soil not only does all vegetation emerge but all such life depends for its continuity upon this upper soil.

The ancients learned another basic fact: this same earth, cooperating with a benevolent sun, provides life sustaining properties and also a most efficient mass sanitary and preservative agent. In diverse ways, as we know from the classical and especially the Biblical literature, the soil and the sun were successfully combined in a multiplicity of ways for the benefit of the human race. Despite the destruction and disintegration of the upper layers of the earth throughout the ages, enough of the past has escaped these dust-returning agents not only to teach us much but to excite our wonder by the magnitude and variety of the existing remains. Many are of special interest to physicians both theoretically and practically.

The medical profession from the very beginning was deeply conscious of the significance of the soil because man's food and water supplies come from this source. The entire range of his daily life and sustenance included problems arising directly or indirectly from the soil. But this knowledge was so basic and so universal he hardly considered such problems as of special interest to him; they were taken as a matter of course. But once he looked more deeply into this matter he discerned that from the good earth came many things which were at the very threshold of his specialty, primarily materia medica. Over long ages, he had come to use through trial and error the elements, the metals, and the minerals (mercury, arsenic, antimony, lead, iron, zinc, silver and gold). These earth products were good; he could hardly treat disease without them.

Again, ages ago some doctors were curious enough about plants to become botanists or herbalists. A few became so skilled in these specialties they made discoveries of plant products which still furnish many of the most valuable plant materia medica appearing in our pharmaeopea: opium, quinine, alkaloids, and scores of oils and laxatives. All were products of the good earth.

More recently the doctor has learned that the end is not yet for the soil is yielding the wonder drugs, largely members of the mold groups — penicillin, streptomyces and actinomyces. They are called antibiotics because of their antagonistic action toward many of our harmful pathogenic germs. These organisms for ages have been living and evolving in large numbers, co-acting with each other in an infinite variety of chemical and physical ways. While long ago we had become aware of some of the marvelous properties of the soil, only now are we discovering through chemistry, physics, biology, bacteriology and mycology, the exact and detailed mechanisms proceeding on a vast scale in this soil. It is some of these complex products that now we are finding to be the most powerful and valuable additions to our materia medica. Again the good earth proves to be not only good but far more beneficent than we ever had dared to hope. With all these interrelations and associations between soil and medicine is it any wonder that doctors should display an interest in land in a variety of ways; and that the relationships between the physician and Mother Earth should develop naturally into a sort of specific affinity.

In the winning of our great West, an Illini country played significant role. Its central location, its accessibility by way of the Great Lakes and the rivers, its vast fertile prairies, together with its many other natural resources were scarcely matched anywhere on this continent. The early peoples who emigrated here were a diversified group of strong and determined characters. Among the rough hardy pioneers of a century and a half ago who traversed the unknown trails and the unbroken roads, there were a relatively large number of well trained and educated men of various professions. Notably was this true of medicine. Many of the pioneers had studied medicine and were competent to practice at once. They were greatly needed and appreciated by the settlers. Others were vigorous young men looking forward to future medical training. One of the customary ways to get started was to acquire the cheap land and to begin at once to till the fertile prairies. Later many used the tenant system to work their farms; others were among our early land promoters and speculators.

Volume I of the History of Medical Practice in Illinois gives in detail the stories of many men who early became either doctor-farmers or farmer-doctors. Some were great in both fields.

Let us mention a few. Dr. John A. Kennicott (b. 1802). Pioneer horseback doctor for 27 years at Northfield (Cook County) Illinois. Owner of a large farm; a noted horticulturalist; one of the founders of the University of Illinois. With J. B. Turner he was largely responsible for our land grant system for state universities.

Dr. Caldwell Cairns came to the Illinois country about 1802. A "sound good physician" of St. Clair County; owner of a splendid farm "Walnut Grove"; later a judge and a framer of the state constitution.

Dr. George Fisher, a noted Doctor of Randolph County; first epidemiologist in Illinois; he erected the earliest smallpox house of refuge on his farm 6 miles from Kaskaskia, where he died in 1820.

Dr. Cyraneus Wakefield (b. 1815) of DeWitt County was a teacher, a doctor, and a farmer; operated later with his brother, a store for farmers, which later became a medicine factory to dispense his chills and fever remedy. The doctor made a fortune.

Scores of such doctors and farmers from Illinois, as from practically all other states, could be listed. They all loved the good earth.

LET'S HAVE YOUR NAME DOCTOR

The revision of the List of Speakers is now under way by the Scientific Service Committee of the Illinois State Medical Society. In response to notices that have appeared in various publications, some 150 physicians have submitted their names together with their preferred subjects.

The Scientific Service Committee believes professional modesty is responsible for the poor response. This is regretful because the Committee would like to have all physicians available to help it render assistance to the county medical societies throughout the state.

How about it Doctor? Are you available? You do not need to be identified with a teaching position on a university staff, nor is it necessary that you have many years of practice behind you. Do you know your subject and can you present it in clear and interesting language?

The Scientific Service Committee is your committee, Doctor. You help maintain it. Why not help it to function in its responsibility of assisting program chairmen and secretaries of county medical societies in arranging their programs?

Mail to Mr. James C. Leary, 185 N. Wabash Room 903.

THE PHYSICIAN AND INFANTILE PARALYSIS

The medical profession is in a position to fight poliomyelitis. For many years our Organization has helped in the March of Dimes, and many members have been active in the year-round work of the local county chapters of the National Foundation for Infantile Paralysis.

We now have an opportunity to participate in the year-round battle and listed below are some ways in which we can help:

1. There is a chapter of the National Foundation for Infantile Paralysis in every county. Please contact them for speakers, films, exhibits, posters, literature and for any information you desire on poliomyelitis. There is no charge for any of these services from the National Foundation.
2. Urge members to learn as many facts as possible about polio and explain these to their employees, co-workers and friends. Information can be disseminated through house organs, posters and displays in offices, factories, etc.
3. Ask members to enlist volunteer assistance to local health officials in the event that your community suffers a polio case load sufficient to result in a mass immunization program with gamma globulin.
4. Ask for cooperation of members should your community be selected for future scientific study.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Maloney, Caesar Portes, William Requarth, Frederick W. Slobe.



"Let's Sue Doc" — A Growing Problem

William C. Stronach, L.L.B.
Executive Secretary, American College of Radiology
Chicago

Your malpractice insurance premium has risen —probably markedly. It is quite possible that your insurance agent has recently informed you that your current insurer does not plan to write this class of business in the future, or that the Company will continue to make its policy available only on an accommodation basis — on the condition that you place other and more desirable insurance with it. Again — you may have been notified that the group plan under which you have been insured is being discontinued, or that certain procedures such as spinal anesthesia are being eliminated from the coverage. You are either generally or specifically aware that more claims and lawsuits alleging malpractice are being currently filed against physicians than ever before. (Perhaps you are even on the receiving end of one of these.) Stories of some really astronomical judgments have surely reached your ears. In short, the malpractice insurance situation is in a chaotic state. Why?

There seems to be broad agreement on several contributing factors. These are:

Inflation — Judgments and expense items are being paid in terms of today's inflated dollars. The juryman who pays twenty-five hundred dollars for a "low priced automobile" and one dollar fifty cents for the Blue Plate Special does not hestitate to award a large judgment in a malpractice suit. For the same reason the courts have allowed these king sized awards to stand.

Publicity — The juryman especially does not pause long because he has become aware — as have people in general — that physicians universally carry professional liability insurance and he has read and heard of extremely high judgments rendered elsewhere. In addition, he may well be one of the many under the impression that "all doctors are rich".

The Times — "Anyway", reasons the juryman, "One hundred thousand dollars is not too much money these days." With talk of multi-billion dollar Federal budgets, big deals by five percenters, and the world owes me a living philosophy that has been prevalent during the past twenty years, his thoughts and actions are merely in tune with the times.

Medical Practice — Nor has social evolution left the practice of medicine untouched. The personal relationship between physician and patient has been diluted by group, clinic and part-

nership practice in which the patient does not always consult with the same physician, and all members of the family so consult almost never. Even in the absence of group practice, specialization has led to a medical fragmentation of the family unit. Father sees the internist; mother the gynecologist; baby is ushered into the world by the obstetrician and then handed over to the pediatrician; the orthopedic surgeon mends the broken bones; difficulties involving the eye are sent to the ophthalmologist; etc. All of this may well be good medicine but it has unquestionably eliminated some of the warm, personal family — physician relationship that once existed. A further impersonalization has sprung from the increased use of the hospital which has taken an ever larger segment of medical practice out of the office and home.

The Law — In some localities rules of law have changed so that it is now much more difficult to defend a malpractice suit than formerly and courts — seemingly increasingly loath to dismiss these actions for a lack of substance — are allowing the issues to go to the jury. Juries today apparently deal less frequently with the question of "whether" to find for the plaintiff - patient, than they do with the question of "how much" damages to assess against the defendant-physician. In addition, one cannot dismiss the legal aspect without comment on the National Association of Compensation Claimant's Attorney's which has been organized to assist lawyers in obtaining "more adequate and equitable judgments for compensation claimants". Since appraisals of both adequacy and equity can and do vary, the purposes of NACCA boil down to larger judgments in all cases brought to bar. To this end the NACCA Law Journal is published and in it successful claim actions, trial procedures and methods of litigation as well as publicity concerning five and six figure judgments are outlined for the benefit of the attorney membership of 1700. Finally, NACCA has a legislative program the objective of which is to amend the laws of the various states to make even simpler the gaining of ever higher awards for claimants.

These are the contemporary social conditions which have adversely affected the professional liability insurance situation; the general scene in which operates the particular motivation for a given malpractice claim.

Why Malpractice Actions? — Let us quickly review the specifics of why patients file such suits against physicians:

Dr. Louis J. Regan reporting for the Committee on Medical — Legal Problems of the American Medical Association has stated, "The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is *criticism by a succeeding physician of the work of his predecessor.* Various authorities have estimated that fifty to eighty percent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticize destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient."

Detroit attorney, Clayton C. Purdy who has handled malpractice cases in fifty-six of Michigan's eighty-three counties agrees in an article in the *Journal of the Michigan State Medical Society* saying, "It is my observation that the thoughtless or inadvertant criticism of one physician of the work of his fellow physician has been the cause of the majority of the unwarranted malpractice actions."

Fee disputes and unwise collection methods probably account for approximately twenty percent of claims. Many of these arise as countersuits to physician's actions for the collection of fees.

An additional group arise when patients are resentful due to their conviction that the doctor has not done his best — that he has been neglectful, disinterested or callous in his dealings.

Other causes are: a guaranteeing of the results of treatment; admissions of negligence made by the physician within the patient's hearing; negligence or error on the part of partners, nurses or office personnel: a failure to gain consent for operation or radiation; and a failure to use methods of diagnosis or treatment conforming to the standard of the community — especially failure to use x-ray in the reduction of fractures.

What Can Be Done? — What, if anything,

can be done to make this gloomy picture brighter? And who can do it?

The secretary of a large American indemnity company which has underwritten professional liability insurance in quantity over a period of years has stated, "We are convinced that this line of insurance can still be covered profitably upon a broad basis — that is not over selectively — but only if the doctors through their professional organizations will assist in all phases of operation. We refer to underwriting in group plans, claim prevention, adjustment and litigation. Lacking such cooperation an insurance company is hamstrung. We need help in all of these areas. The heart of the problem, however, is claim prevention. Acting unilaterally we are all but powerless to prevent claims — which many times, of course, blossom into lawsuits. This is because in every case a physician — sometimes our insured and sometimes another — creates the claim situation. We cannot deter such actions from the disadvantage point of the home office."

Claim Prevention — What, then, are the constituents of a claim prevention program for the profession and where can it be best organized?

There are aspects which can be undertaken on a national, state, or local basis and which may well be carried on at all levels simultaneously. There should be a continuous educational program to bring home to the individual physician those situations, or actions, that have created claims against other physicians. For instance, all physicians should know that when a diagnostic radiographic cone falls upon an injured part, an immediate question arises as to how much of the injury was caused by the original accident and how much by the falling cone. Sometimes it takes a lawsuit and the opinion of a jury to answer this question. It nearly always costs money. This is the type of claim cause that is avoidable.

Physicians must continue to be informed as to the seriousness of the professional liability insurance situation and urged to conduct their personal relations with their patients in a manner that will enhance not only their own standing, but also reflect to the credit of medicine. In 1952 approximately one doctor in thirty-eight was sued. This spells poor personal and public relations.

At the national level the A.M.A. study of the overall malpractice insurance problem should be continued and expanded. Only by sifting and straining all methods of claim prevention, underwriting, group buying, adjustment, and litigation, can a solid mass of information be developed.

The State Association — Group programs for purchasing malpractice insurance, where they are deemed to be desirable, will probably have to be organized on a state basis except in the largest counties. Parenthetically, it is believed that group plans at the national level are unsound unless they can be administered and guided locally. The nation is too large a unit for effective advice on underwriting or within which to move with dispatch in claim situations.

A good job of stimulating acceptance can be done at the state level as is indicated by the New York State Medical Society's sixty-five percent eligible physician participation and the Oklahoma State Medical Association's approximately eighty percent.

Group malpractice and defense boards may well function within state associations. Where a state association professional liability insurance policy is in force, the board can conduct a statistical control of rates and classifications of coverage as indicated by experience, and be charged with final responsibility for underwriting — that is the responsibility for curtailing or refusing coverage, and recommending special riders excluding or limiting liability on certain procedures or methods. Claim adjustment can profitably be centralized under the board. Inexperienced men should never be employed to adjust malpractice claims. A seasoned, tactful and wise adjuster may spell the difference between a fair, honest settlement and a lawsuit.

With or without a group insurance program, the state board can retain competent attorneys to defend all malpractice suits brought against members of the association, or to be available for consultation in such defense. This is a highly specialized field of law and an attorney's effectiveness normally bears a direct relationship to his experience.

The County Society — The spade work must be done in the county medical society. A complete county medical society program for malpractice prophylaxis will entail a public relations service which will bring to the attention of the

patient-public the good things done by the society and its members; an emergency medical service; social welfare assistance; a competent and wisely directed collection service; and — most important — a grievance or mediation committee to which the public is urged to bring complaints as to treatment, results or fees. While certain of the elements of such an overall program may be beyond the financial resources of many county medical societies, there is scarcely a society so small that it cannot have a mediation committee. And it is not enough to simply have such a group "on paper", it must work diligently and publicly with the society standing behind its recommendations. It should have among its members, or advisors, competent specialists who will go into court to testify either for doctor or for patient, depending upon findings. In the public and professional recognition of the authority and objectivity of such a committee will lie its relative success or failure.

County societies should studiously consider the applicability of experiments conducted elsewhere. An instance is the recently inaugurated New York City program under which a panel of society appointed specialists have been made available to the courts to take part in efforts for pretrial settlement of suits with medical aspects.

The Present Picture — In 1929 400 malpractice cases were filed — in 1952 some 4,000. Recent malpractice judgments of $50,000 and $100,000 are in the record. From 1941 to 1951 the average amount of the jury verdict in New York's trial courts increased 149 percent while the cost of living index advanced half that amount. In Nebraska a physician's insurer was placed in the position of having to make a multi-thousand dollar settlement due to the "hypothetical case" depositions of physicians who never saw the patient, never talked to the doctor involved, and never saw the case records. State and national medical associations have had group plans terminated by insurers due to adverse loss experience. In at least one state some premiums rose 850 percent last year. There are areas in which certain sound and desirable medical procedures have been all but abandoned due to adverse court decisions and ensuing publicity.

Methods of combatting this trend are known. The devices herein outlined are being currently undertaken by national, state and county medical groups. In general, however, efforts have been uncoordinated and application spotty. There is much to be gained through a well organized program of malpractice prophylaxis: the future insurance market or lack thereof; improved public relations for organized medicine; and the preservation of the personal relations, reputation and financial solvency of many individual physicians.

20 N. Wacker Drive.

THE P.R. PAGE



Read the PR Pamphlet

The new pamphlet on county medical society public relations programs has gone to every county secretary. It is the hope of the Committee on Medical Service and Public Relations that each secretary will read it carefully and examine his own society's program in the light of its recommendations. If help or suggestions are needed, consult the committee.

Never Underestimate The Power, Etc., Etc.

The Woman's Auxiliary to the Winnebago County Medical Society turned in a superjob on nurse recruitment last month. Under the leadership of Mrs. W. J. Bryan, new president, and Mrs. Joseph S. Lundholm, committee chairman, and with the earnest co-operation of all the members, the Auxiliary planned and staged a Boys' Choir concert which raised $13,795.

As an added incentive, Mrs. Bryan wrote to a number of famous women like Mrs. Governor Stratton and Ambassador Claire Booth Luce and various motion picture stars, and talked them out of old hats, which were auctioned off during the concert intermission.

The money will be used as the nucleus of a Student Nurse Fund, which will pay tuition for intending nurses and which is dedicated to the nurses of the armed forces.

The Auxiliary did a superb publicity job, collecting some fifty-odd clippings from the two local papers over a two-month period, but the ticket-selling work of the whole organization really put the program over. They filled all the 1,435 seats in the Rockford Shrine Auditorium and some over.

Patient Relations Pamphlet

Dr. Walter L. Portteus of Franklin, Ind., at the recent annual meeting of the Indiana State Medical Society, distributed samples of a new pamphlet which explained all the phases of medical fees. It elaborates on the theme of the A.M.A. plaque which invites patients to discuss fees frankly and fully, and goes into the details of the various separate fees involved in surgery.

The P.R. Problem of Science — Still Another Viewpoint

For another view of the public relations problem of science, turn to a recent issue of Science, where Herbert Curl and Nicholas Rescher of the Marine Corps Institute at Washington put forward a suggestion.

"Science needs outstandingly good public relations," they wrote. "In an age in which organized social pressure is the most potent political force, science cannot afford the risks of isolation or misunderstanding. The many signs that something is amiss here reveal a great potential danger."

They cite the "inordinate public respect" for science which is disturbed proportionately when some great scientist sounds off as an authority on

non-scientific subjects. Then, in some quarters, they find an "extreme and unreasoned contempt" for science; instanced in various groups like the antivivisectionists and antievolutionists. Science education fails, too, they believe, while politicians can push government scientists around with impunity.

Reasons cited include: Failure to establish a perspective on science, an intellectual withdrawal of scientists who fail to make their work accessible, and the increasing specialization of science.

What to do? Let every scientist be a publicist, work only under honorable conditions, become an active part of the community.

Finally, the two suggest a non-profit, non-government, non-political institute, solely to improve the public relations of science — disseminate information, debunk false claims, detect frauds and fads, preach basic research and pure science.

"If the scientist is to be a prophet with honor," they insist, "it can only be by dint of concerted and sustained effort."

School Health Programs Outlined at Conference

The A.M.A. and the National Education Association at the fourth national conference on physicians and schools recently outlined in detail the organization, functions, methods and interrelationships of a medical society school health committee. Dr. John L. Reichert of Chicago, chairman of the child health committee of the Chicago Medical Society, acted as chairman. His important and interesting report should be of value to every school health chairman as the first really clear delineation of this delicate problem.

New Grievance Committee Report Printed by A.M.A.

The A.M.A. has just published a new report up to date on the operation of grievance (mediation) committees in the various state and county medical societies. A second summarizes the activities of county medical societies throughout the United States. Both provide valuable statistics on the extent and intensity of the manifold programs in operation.

SPLENECTOMY (Continued)

Spleen with Thrombocytopenic Purpura. J.M. Soc., New Jersey 47: June 1950, pp. 272-275.

8. Partenheimer, R. C. & Meredith, H. C. Jr. Splenomegaly with Hypersplenism. New Eng. J.M. 243:21 Nov. 23, 1950, pp. 810-2.
9. Piney, A. & Ross, M. S. Sarcoidosis of Spleen and Bone Marrow. Tubercle 33:1 Jan. 1952, pp. 24-9.
10. Pinner, M. Non-Caseating Tuberculosis. Amer. Rev. Tbc. 37:690, 1938.

OBESITY

The obesity problem is fertile for research. We should like to know, for example, what benefits in longevity accrue to the middle aged person who reduces and maintains the reduction. We need clarification of the mechanism, psychological or metabolic, that leads to overeating. *William H. Sebrell, Jr., M.D., Nutrition Research . . . Potentialities in Chronic Disease. Pub. Health Rep., Aug. 1953.*

PARASITES

A word of warning concerning the microscopic examination for parasites is here in order. While every laboratory technician may be competent to examine stool for blood and fat, this does not hold true for examination for parasites. For the latter, one must have a technician trained particularly in parasitology. It is better to send a stool to a distant but reliable laboratory for parasitic examination rather than to rely upon an inexperienced local technician. Poor examination of stool specimens account for many undiagnosed cases of amebiasis and other parasitic diseases in patients who continue with chronic diarrhea for months and years. *Frederick Steigmann, M.D., Chronic Diarrhea .. Diagnosis And Management. J. Indiana M.A., March 1953.*

KNOW YOUR SOCIETY

CONSTITUTIONAL COMMITTEES

Ethical Relations Committee. The Ethical Relations Committee is appointed by the Chairman of the Council, but its functions are outlined in the By-Laws under Chapter XII- DISCIPLINE — Section 7. After the Ethical Relations Committee of a county medical society, as the "sole judge of its membership", has taken action in a trial, the accused must be notified by registered mail that he has the right to appeal to the Council of the Illinois State Medical Society within thirty days.

"Such appeals shall be referred to the Ethical Relations Committee of the Council of the State Society which shall review the case. The members of the Ethical Relations Committee of the Council shall refrain from interrogation of the respondent or witnesses, except in such instances as some question may be necessary to clarify a doubt existing in the questioner's mind. When there is such a question, it shall be addressed to the presiding officer.

"On conclusion of the hearing the Ethical Relations Committee of the Council shall meet in executive session to consider its decision, and shall report in writing to the Council at its next meeting for final action.

"The appeal shall consist ONLY OF A REVIEW AND A HEARING AS TO THE REGULARITY OF THE PROCEDURE AT THE FORMER TRIAL."

Therefore, the Ethical Relations Committee of the Council of the State Society is a "reviewing body", set up to determine whether or not the accused has had a fair trial at the county level. In case the committee findings are against the accused, the secretary of the State Society must notify the accused within ten days by registered mail of his right to appeal to the Judicial Council of the American Medical Association. If the Committee finds that an unfair trial, or improper procedure of trial or findings or an unconstitutional hearing has been held, the case must be remanded to the component county society for reconsideration at that level.

This should be impressed upon the membership at the county level so that the members of a county society are ready and willing to assume the responsibility of disciplining the members of their county organization; or maintaining the high and idealistic standards set by medicine; of "cleaning house" at the grass roots, and of carrying out the intent of the Constitution and By-Laws that the County Medical Society shall be the sole judge of its membership. This is a right, a privilege and a responsibility of the county society, with the Ethical Relations Committee of the Council to act as a reviewing body to see that the accused has a fair and just trial.

(2) Fifty Year Club Committee. In 1937 the

"Fifty Year Club" was formed to honor physicians who had practiced medicine for fifty years. This is a club without dues, without officers, and without responsibilities. Membership is secured by a recommendation from the physician's county medical society addressed to the secretary of the state society.

The Fifty Year Club Committee has been appointed each year since 1937 by the Council to function for the Club. Dr. Andy Hall of Mt. Vernon has been chairman of the committee since its founding in 1937. He acts as toastmaster at the annual complimentary luncheon given the members of the club at each annual meeting of the Illinois State Medical Society in May.

This is a group of which the State Society is justly proud; it is an honor for the Society to be able to give recognition to the men and women who have devoted so much time and effort to their chosen profession. Illinois, to the best of our knowledge, founded the first Fifty Year Club in this country. The idea has spread, and now many state societies have similar clubs or organizations. Another Illinois "first", and an example of the efforts made by the State Society to stay in the vanguard of all phases of medicine.

(3) Interprofessional Relations Committee. The Interprofessional Relations Committee is exactly what its name implies. Its members are entrusted with the responsibility of maintaining close and cooperative relations with dentists, pharmacists, nurses, optometrists and veterinarians, etc. The members of this Committee have helped to develop the Interprofessional Council, an active organization composed of the various professional groups whose interests are similar and whose problems overlap in many fields. Dr. Wayne B. Slaughter of Chicago has been the chairman of our Council Committee for several years. The Committee and also the Interprofessional Council feel that groups of this type should be developed at the county level; that joint meetings of the medical society, the bar association, the pharmacists, the dental society, etc., can and do create better working conditions for the professions in any given area.

This committee would be pleased to cooperate at the county level, and give assistance to local groups at any time to foster good public relations.

(4) Committee on Industrial Health. This committee can serve you. "At this time the future of industrial medicine in this country rests in the hands of the general practitioner of medicine. Future progress in industrial medicine and future improvement in industrial health will be measured by the extent of the general practitioner's participation and the degree of competence which he develops in this relatively new and difficult professional specialty". (That's a quotation from a symposium on Industrial Medicine given at Harvard School of Public Health).

A letter to the chairman of this committee will give you detailed information on industrial health programs for small companies; he will give you a list of readable and authentic books for the use of the general practitioner or the industrial physician and he has suggested the following Journals:

Archives of Industrial Hygiene and Occupational Medicine: Published by The American Medical Association. Annual subscription $8.00.

Industrial Medicine and Surgery: Published by The Industrial Medicine Publishing Company, 605 N. Michigan Ave., Chicago. Annual Subscription $6.00.

Books recommended include "Occupational Medicine and Industrial Hygiene" by Dr. Rutherford T. Johnstone; The C. V. Mosby Company, St. Louis, Mo.

The work of the committee is concrete, active, helpful. It is a service maintained by the State Society for the benefit of its membership — and included in "what you get" for your dues. The members of this committee are working in the field of industrial medicine and surgery, and they are ready and willing to pass on information and assistance to any member who needs help.

The Committee is working for legislature to improve working conditions; it is serving in an advisory capacity to business when invited to act in this capacity; it is working for the residents of the state of Illinois and for the members of the profession to better conditions in the industrial field in its many and diverse phases.

If you wish to take advantage of this service, as a member of the Illinois State Medical Society, you may write to Dr. Lloyd E. Hamlin, Chairman Committee on Industrial Health, 2501 Blue Island Avenue, Chicago, Illinois.

CORRESPONDENCE



SPECIAL NOTICE ON PREMATURE PROGRAM

Pursuant to the meetings of the Premature Center Advisory Committees at St. Francis Hospital in Peoria, St. Johns Hospital in Springfield and Christian Welfare Hospital in East St. Louis, the following changes in eligibility for admission to Premature Centers of premature infants not on a private patient basis are as follows:

1. Payment for care by the Department of Public Health may only be made for premature infants whose weight is 4½ pounds or less at the time of admission to the Center and program.

2. Application for admission to a Center should be made as soon after birth as possible and admission of the infant completed not over seven (7) days following delivery to be eligible for any payment by the Illinois Department of Public Health.

With the exception of these two items, the same conditions remain as described in the letter of March 9, 1950. The Department of Public Health determines from the information submitted on the application form (MCH P-1b Admission Record) the need of the family for financial assistance in caring for the eligible premature infant at a downstate Premature Center. That portion, if any, which the family can pay, is to be paid to the Center hospital under arrangements made by the hospital with the family.

These limitations do not apply to private cases, and the portion of the application form entitled "Parents' Statement for Care Under the Program" need not be completed for such cases. If the Department of Public Health finds the family is able to pay the entire cost of care, the family may expect to receive statements from the hospital and the physicians concerned. However, ambulance service for private cases will be provided if requested, since specialized equipment plus skilled nursing care for premature infants is not otherwise ordinarily available.

You are invited to make contact with the Center hospitals or this Department for additional information regarding the program or specific cases.

SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY

The eighth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 18, 1954. The lectures on Ophthalmology will be presented on January 18, 19 and 20, and those on Otolaryngology on January 21, 22 and 23. A midweek feature will be the Midwinter Convention of the Floradi Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 20, to which all registrants are invited. The registrants and their wives may also attend the informal

banquet at 8 p.m. on Wednesday. The Seminar schedule permits ample time for recreation.

The Seminar lecturers on Ophthalmology this year are Dr. W. B. Anderson, Durham, N. C.; Dr. W. P. Beetham, Boston; Dr. W. C. Owens, Baltimore; Dr. A. B. Reese and Dr. M. C. Wheeler, both New York City. Those lecturing on Otolaryngology are Dr. E. N. Broyles, Baltimore, Dr. H. P. House, Los Angeles; Dr. W. J. McNally, Montreal, Canada; Dr. Dorothy Wolff and Dr. D. Woodman, New York City.

ASSOCIATION FOR RESEARCH IN OPHTHALMOLOGY

The Midwest Section of the Association for Research in Ophthalmology will hold its annual meeting Sunday, February 7, 1954 at the University of Chicago, School of Medicine, Chicago 37, Illinois.

Papers of clinical and basic interest will be presented with many presentations of a preliminary nature. Dr. Theodore F. Schlaegel, of the Department of Ophthalmology, University of Indiana, is the Chairman.

The meeting will be preceded by the Annual Clinical Conference of the Chicago Ophthalmological Society, which will be held Friday and Saturday, February 5 and 6, 1954, at the Drake Hotel.

Frank W. Newell, M.D.
Secretary-Treasurer
Midwest Section, Association
for Research in Ophthalmology
950 East 59th Street
Chicago 37, Illinois

INDUSTRIAL HEALTH FELLOWSHIPS

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Service in the Armed Forces or private practice may be substituted for one year of training.)

The course of instruction consists of a two-year period of intensive training in Industrial Medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from $2,100 to $2,700 in the first year and $2,400 to $3,000 in the second year. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

A one-year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health. College of Medicine. Eden and Bethesda, Cincinnati 19, Ohio.

NEWS OF THE STATE



ADAMS

Society News.—Dr. W. H. Newcomb, Jacksonville, Councilor of the Sixth District, which includes Adams County, addressed the Adams County Medical Society, in Quincy, October 17, on the activities of the Illinois State Medical Society. At this meeting Dr. Robert W. Taylor, Quincy, was elected to membership in the society. All members of the society were urged by its public relations committee to give liberally to support the Community Chest.

Medical Society and Health Department Sponsor Telecast.—The Adams County Medical Society and Adams County Health Department are sponsoring a weekly television program entitled "YOUR HEALTH" over Hannibal-Quincy Station KHQA-TV Channel 7, each Friday evening at 8:00 P.M., for the Fall, Winter and Spring season.

For this highly entertaining and educational series the Medical Society and Health Department are receiving the cooperation of the American Medical Association, Illinois State Medical Society, Illinois State Department of Public Health, American Cancer Society, American Heart Association, American Crippled Children and Adults, National Foundation for Infantile Paralysis, National Tuberculosis Association, and other leading medical and health organizations. Talent from the Quincy Little Theater and the Dramatic Club of Quincy will be used on some of the programs.

KHQA-TV Channel 7, has the tallest broadcasting tower in Illinois, Missouri, and Iowa, and is the C.B.S., Dumont and Station WTAD affiliate for the Hannibal (Mo.) Quincy (Ill.) Keokuk (Ia.) area. Be sure to tune Channel 7 each Friday night at 8:00 for this interesting TV program.

BUREAU

North Central Medical Meeting.—The seventy-seventh annual meeting of the North Central Illinois Medical Association was held at St. Margaret's Hospital, Spring Valley, November 5. The afternoon program consisted of the following: J. Ernest Breed, M.D., Chicago, "Isotopes and Cancer"; Edward Gallardo M.D., LaSalle, with C. W. Weidenheim, M.D., Princeton, "Eplithelial Downgrowth after Cataract Surgery with a Note on X-ray Treatment"; Dexter Nelson, M.D., Princeton, "Cardiac Irregularities"; Ward H. Eastman, M.D., Peoria, "The Surgical Treatment of Mitral Stenosis"; Clayton T. Beecham, M.D., Philadelphia, Pennsylvania, "Management of the Diseased Cervix"; Raymond W. Fricke, M.D., Bloomington, "Treatment on Varicose Veins." In the evening Dr. Raymond E. Davies, Spring Valley, delivered the presidential address and presented life memberships in the Society to Drs. Wilbur Lorenzo Bowen, Peoria, Charles Daniel Sneller, Peoria, Verne Hays, Canton. The principal address of the evening was presented by Dr. Walter C. Bornemeier, Niles, President of the Chicago Medical Society, on "Medical Care Plans for the Future." Dr. Bornemeier was awarded an honorary membership in the North Central Illinois Medical Association. The group comprises the counties of Bureau, DeKalb, Grundy, Kendall, LaSalle, Lee, Livingston, Marshall, Putnam, Whiteside, Woodford. Officers of the society are Dr. Davies, president, Dr. Otis H. Law, Pontiac, first vice-president, Dr. Ward H. Eastman, Peoria, second vice-president. Dr. George A. Dicus, Streator, was reelected secretary-treasurer of the organization for the fifty-fourth consecutive time.

CLINTON

Thirty-Five Years of Practice.—The Carlyle Union Banner, on October 8, wrote a eulogy to Dr. Ernst Charles Asbury, on his thirty-five years of practice in New Baden. The story reviews Dr. Asbury's experiences while he was earning the money to provide for his education at the St. Louis University School of Medicine where he graduated in 1889. "The profits from the sale of some pigs paid my tuition", Dr. Asbury is credited saying. "Then I tried my hand as a carpenter and construction laborer. Must have been pretty good, too, for in my spare time in the summer of 1908, while working as a carpenter, I built myself a house. Later on I sold it for $375 above the net cost. That house, by the way, is still standing," Dr. Asbury stated. His principal hobby is the breeding of Aberdeen black Angus cattle, the newspaper reported.

COOK

Annual Lectureship of Phi Delta Epsilon.—The chapters of Phi Delta Epsilon Fraternity of Northwestern University Medical School, University of Illinois College of Medicine, and the Chicago Medical School, designated their annual lectureship November 10, 11, and 12, in honor of Dr. Isaac Abt, professor emeritus of pediatrics at Northwestern; Dr. Julius Hess, professor emeritus of pediatrics at Illinois, and Dr. John Sheinin, president of the Chicago Medical School. Paul C. Aebersold, Ph.D., director of the Isotope Research of the Atomic Energy Commission, Oak Ridge, Tennessee, gave the three lectures as follows: November 10, at Northwestern on "Contribution of Atomic Energy to Medicine;" November 11 at Illinois, "Radioisotopes-Tools for Medicine," and November 12, Chicago Medical School, "The Use of Radioisotopes in Medical Research, Diagnosis and Therapy." The dinner in honor of Drs. Abt, Hess, and Sheinin was held on November 10.

Appointments at County Hospital.—New appointments recently announced by Dr. Karl A. Meyer, medical superintendent of Cook County Hospital, include those of the following: Dr. George C. Blaha, medical director of Cook County Hospital; Dr. Samuel Hyman, assistant medical superintendent of Cook County Hospital; Dr. Sinclair Howard Armstrong, Jr., director of medical education at the Hospital. Dr. Armstrong will also serve in an advisory capacity at the Hektoen Institute for Medical Research and serve as professor of medicine at the University of Illinois College of Medicine.

School Reports on Toxicology Services.—A total of 631 cases was handled during the 1952-53 fiscal year by the Division of Toxicology of the Department of Pharmacology at the University of Illinois College of Medicine, it was reported October 13.

Dr. W. J. R. Camp, professor of pharmacology and toxicology and state toxicologist, stated that 491 cases were handled for the coroner of Cook County. Cases from other sources number 140. Many of these involved multiple analyses.

The University maintains a toxicological analytic service for law enforcing agencies, physicians, and hospitals of the state. Specimens never are accepted from lay individuals. The service is available only to state's attorneys, hospitals, and physicians in Illinois, most of whom do not have adequate facilities for the accurate diagnosis of death due to poisoning.

Services performed include blood alcohol, barbiturate, heavy metals, carbon monoxide poisoning, and alkaloidal analysis, and a complete analysis in the event the cause of death is unknown. A nominal fee is charged for these services.

Illinois Interprofessional Council.—The first annual meeting and luncheon of the Illinois Interprofessional Council was held at the Sheraton Hotel, November 15. The meeting served as a progress session to show the accomplishments made since the organization was created. Dr. Glenn Moore gave the progress report. Senator George Drack discussed "Socialism and Ethics." Chairmen for the occasion were: Wayne Slaughter, M.D., Medicine; Arno L. Brett, D.D.S., Dentistry; Ralph Barton, O.D., Optometry; Phillip Brachman, D.S.C., Chiropody; C. L. Miller, D.V.M., Veterinary Medicine; Ralph Carpenter, Pharm. D., Pharmacy.

New Gift to Cancer Foundation.—One hundred thousand dollars a year will be contributed to the University of Chicago Cancer Research Foundation by Maurice Goldblatt, according to release from the University of Chicago School of Medicine. The money will provide research funds for younger investigators. The general contributions will be made available through 1,000 associates, considered a new class of members to the Cancer Foundation. Each of the associates will contribute $100 a year and will receive periodic reports on research work as well as meet with the doctors and scientists at an annual dinner meeting to discuss progress. According to the news release, organization of the associates will be confined to Chicago at the start, but by next spring Mr. Goldblatt intends to invade, on behalf of the associates, the various parts of the country where he has a wide acquaintance.

Resurrection Hospital Dedicated.—On November 1 the Resurrection Hospital, costing four million dollars, was formally dedicated with appropriate ceremonies and with Cardinal Stritch presiding. The new institution has 176 beds and forty bassinets. Presently the building consists of a fully utilized ground floor and four complete stories, but it is hoped, according to newspaper reports, to continue the building plans to construct eventually a fifth floor which will bring the hospital to a 250 bed capacity. Food, laundry and refrigeration facilities occupy the basement. The first floor houses the administration offices, the suites for surgery with all

the accompanying laboratories and supply rooms, as well as a chaplain's suite, gift shop, soda fountain, and the doctors' lounge and library. The second and fourth floors will be devoted to surgical and medical patients and a wing of the fourth floor will be occupied by a pediatrics department. The obstetrical department will be confined to the third floor. In the south wing of the building the second and third stories contain the chapel and the living quarters for the administrative staff.

Annual Dinner Meeting of Institute of Medicine.—Dr. Lewis J. Pollock delivered the presidential address at the thirty-eighth annual dinner and meeting of the Fellows of the Institute of Medicine of Chicago at the Furniture Club of America, December 7. His subject was "Curare and Foments."

Diagnostic Clinic at Swedish Covenant Hospital.—A diagnostic clinic with patient demonstration was given by the Swedish Covenant Hospital, October 21, in cooperation with the Chicago Heart Association. Arranged by Dr. George A. Hellmuth, chairman of the postgraduate subcommittee of the scientific section of the Chicago Heart Association, and Dr. Walter F. Priest, chairman, the following participated: Frank B. Kelly, Sr., M.D., professor of internal medicine, University of Illinois College of Medicine, and George K. Fenn, M.D., professor of medicine, Northwestern University Medical School.

Faculty Changes.—Recent changes in the faculty at the Chicago Medical School include the following: Dr. Walter A. Adams, from associate to assistant clinical professor of psychiatry; Dr. Francis O. Lamb, from associate to assistant clinical professor of psychiatry; Dr. Bernard Skorodin, from associate to assistant professor of psychiatry; Dr. Maria W. Piers, from instructor to assistant clinical professor of psychiatric social work; Dr. Maxwell M. Corbett, from assistant to instructor in orthopedic surgery. Recent appointments to the faculty include the following: Dr. Herbert J. Hadler, associate in surgery; Dr. Joseph A. Cohen, clinical associate in medicine; Dr. John H. Chiakulas, instructor in anatomy; Dr. Richard H. Kosterlitz, instructor in medicine; Dr. George N. Lewis, clinical instructor in medicine, and Dr. Bernard Block, clinical assistant in pediatrics.

Lecturers on History of Medicine.—The Chicago Medical School inaugurated a series of lectures, October 13, on the history of medicine, with an introduction by Mr. J. Christian Bay, librarian emeritus, John Crerar Library. Other lecturers in the series were: Dr. Erwin H. Ackenecht, professor of the history of medicine, University of Wisconsin Medical School, October 20, on Ancient Medicine; Dr. Frederick Stenn, lecturer, history of medicine, University of Illinois, October 27, on Greek Medicine; Dr. Ilse Beith, assistant professor of history of medicine, University of Chicago, November 3, on Oriental Medicine; Dr. A. Levinson, professor of pediatrics, Northwestern University Medical School, November 10, on Medieval Medicine; Dr. Barry Anson, professor of anatomy, Northwestern University Medical School, November 17, on Medicine of the Sixteenth Century; Dr. D. J. Davis, professor of pathology, University of Illinois, November 24, on American Medicine.

Grant for Research.—A six thousand dollar grant from the United Cerebral Palsy Association of Chicago has been received by Northwestern University for its research under Harold Westlake, Ph.D., in the speech development of children with cerebral palsy.

New Recipients to Abbott Professorships.—New appointments to hold the Wallace C. and Clara A. Abbott professorships for the academic year 1953-54, were recently announced by Dr. Richard H. Young, dean of the Northwestern University Medical School. The new recipients are Dr. Carl A. Dragstedt, professor of pharmacology and chairman of the pharmacology department; Dr. Fred S. Grodins, professor of physiology; Dr. Willard T. Hill, associate professor of pathology; Dr. E. Albert Zeller, professor of biochemistry, and Professor Allen Lein, Evanston, associate professor of physiology. Funds for support of the professorships come from proceeds from a gift established in 1937 by trustees of the Clara A. Abbott trust. The gift funds are used by the medical school to benefit the cause of medical, surgical and chemical science.

University News.—Dr. David J. Davis, professor of pathology, emeritus, gave a University lecture at the University of Illinois College of Medicine, October 14, titled "The Medical History of the Four Voyages of Columbus."

Personal.—Dr. August F. Daro was recently elected chairman of the obstetrical and gynecological section of the International College of Surgeons.

Society News.—Dr. Enrico Ciocatto. professor of anesthesiology, University of Turin, Italy, and editor-in-chief of the Italian Journal of Anesthesiology, was the guest speaker at a dinner meeting of the Illinois Society of Anesthesiologists in Chicago, October 10. Dr. Ciocatto discussed "Peridural Segmental Block."

DU PAGE

Dr. Marquardt Honored.—Dr. E. W. Marquardt, Elmhurst. was inducted into the Fifty Year Club of the Illinois State Medical Society at a meeting of the DuPage County Medical Society, October 21. Presentation of the certificate and gold pin emblematic of the honor was made by Dr. George Kirby, second vice-president of the Illinois State Medical Society. Among those in attendance at the presentation ceremonies, held at the DuPage Memorial Hospital, were Drs. Samuel K. Lewis, president, and A. R. Rikli, secretary-treasurer, respectively, of the DuPage County Medical Society. Dr. Marquardt was the 923rd doctor in Illinois to receive the fifty-year award from the state society since the Fifty Year Club was established fifteen years ago.

Dr. J. M. McClanahan, Kirkwood, was the first recipient of the Fifty Year Club insignia and the presentation was made by Dr. Harold M. Camp, Monmouth, secretary-treasurer of the Illinois State Medical Society. Dr. McClanahan graduated at the Chicago Medical College which subsequently became Northwestern University Medical School. He was past the age of ninety when he was inducted into the Fifty Year Club.

County Public Health Council Holds Meetings of Community Interest.—On October 14, the DuPage County Public Health Council held the first meeting in a series of four on topics of interest to the local community. "The Four Leading Causes of Death in DuPage County" was the theme of the first meeting with the speakers being Drs. Glenn L. Judson, Samuel K. Lewis, Edwin F. Neckerman and Kenneth S. Nolan. The three remaining meetings will be devoted to "Protecting Our Health Through a County-wide Food Ordinance;" "Planning for a Healthy Summer", and "Population Trends—The Effect on Health in DuPage County."

KNOX

Regional Clinical Conference.—The Illinois Heart Association, in cooperation with the Knox County Medical Society, held a Regional Clinical Conference at the Custer Hotel, Galesburg, October 21. Speakers included the following: Carl J. Marienfeld, Chicago, Latest Development in the Diagnosis and Treatment of Rheumatic Fever; Robert R. J. Hilker, Chicago, Recent Developments in the Treatment of Hypertension; Robert W. Elliott, Alton, Drug Therapy in Cardiovascular Diseases; Benjamin Pearlman, Chicago, Recent Advancements in Management of Coronary Disease; Warren F. Pearce, Quincy, Program of the Illinois Heart Association and How it Serves the Physician.

Society News.—Dr. Carlo Scuderi, Chicago, addressed the Knox County Medical Society at a meeting in Galesburg, recently, on compound fractures. Dr. Scuderi appeared under the auspices of the Scientific Service Committee of the Illinois State Medical Society. Dr. H. Kenneth Scatliff, assistant director of Blue Cross and Blue Shield, discussed the management of future plans of both organizations.

LAKE

Society News.—At a meeting of the Lake County Medical Society, October 13, at the Lake County Tuberculosis Sanatorium, Dr. Smith Freeman, professor of biochemistry and experimental medicine at Northwestern University Medical School, spoke on "Acute and Chronic Renal Failure."

Personal.—Dr. William A. Mudge was admitted to the Lake County Medical Society by transfer from the Marinette County, Wisconsin, Medical Society. Dr. Peter J. Kearney has been accepted as a member of the society.—Dr. Walter J. Reedy has been appointed physician of the Waukegan High School.

MORGAN

Physician Honored.—Dr. Frank A. Norris, Jacksonville, was inducted into the Fifty-Year Club of the Illinois State Medical Society at a meeting of the Morgan County Medical Society in Jacksonville, September 30. Presentation of the fifty-year insignia, comprising a plaque and gold pin, was made by Dr. Warner H. Newcomb, Jacksonville, Councilor of the Sixth District of the Illinois State Medical Society.

MC DONOUGH

Dr. Hartman Honored.—Dr. Harold M. Camp, secretary of the Illinois State Medical Society, Monmouth, addressed the McDonough County Medical Society November 27 on "Keep Your Public Relations Showing." Dr. Camp was on his way to address the society September 25, when he was injured in an automobile accident. Highlight of the evening was the induction into the Fifty Year Club of the Illinois State Medical Society of Dr. William M. Hartman, Macomb. Dr. Charles P. Blair, Monmouth, presented the insignia to Dr. Hartman.

ROCK ISLAND

Society News.—Dr. Jackson P. Birge, health officer of the Northwest Regional Office, addressed the Rock Island County Medical Society at the Moline Public Hospital, October 13, on "Gamma Globulin in Relation to Polio."

VERMILION

Society News.—Dr. Norman B. Roberg, Chicago, discussed "Obesity and its Practical Aspects in Disease" before the Vermilion County Medical Society at the Hotel Wolford, Danville, October 6.

WINNEBAGO

Plan to Expand Medical Library.—The Winnebago County Medical Library will be greatly augmented under a new program approved by the County Medical Society. Known as "Add-A-Book-A-Year" plan, a volunteer committee has been set up to review new books in certain fields. The recommendations concerning the value of the book as an adjunct to the library will be submitted to the library committee which will make the final selections. In addition, a pool of donators has been set up to be drawn upon for book purchase. Members from the pool will be asked, in rotation, to donate various volumes.

Proposed Weight Control Program.—At a meeting of the Winnebago County Medical Society in May, a proposed program for weight reduction was approved. It is hoped, as the program has been developed in Winnebago County, to reach two aspects to the problem of overweight-prevention and treatment. The objectives of the program are to alert people to the seriousness of overweight as a health hazard, rural and urban, youth and adults; to point out the advantages of having desirable weight and stimulate interest in wanting to attain desirable weight; to provide information that will help people achieve and maintain desirable weight

in healthful ways; to encourage people with special weight control problems to see their family physician, and to urge people who have desirable weight now to watch it and maintain it. The project was initiated through the Health Committee of the Council of Social Agencies. Cooperating groups are the Winnebago County Medical Society, County Chapter of the Illinois Heart Association, Winnebago County Home Bureau, and the Council of Social Agencies. Its aim is entirely educational and will have two main phases: an extensive phase consisting of general information through county-wide mass media and an intensive phase including group meetings.

It is hoped to set up instructional meetings whereby people may learn about weight control and discuss their problems in friendly groups. None can attend the course, however, without a physician's certificate. This certificate will be made available after the physician's examination, when he then may recommend a desirable weight loss or weight gain for the patient, as well as the caloric content of the diet he wishes the patient to follow. Certificates will be made available to the individual physician, for his office use, and to the public at the time of the initial meeting, November 17. In addition, the application forms, with the physician's certficate, will be made available to service clubs in the area. The forms are to be taken to the individual's own physician for completion and recommendations.

Joint Meeting.—A joint meeting of the Winnebago County Medical Society and the Illinois Chapter of the American College of Chest Physicians was addressed at the LaFayette Hotel, Rockford, November 13, by Drs. Edwin R. Levine, assistant clinical professor of medicine, Chicago Medical School, on "The Management of Bronchial Insufficiency", and William M. Lees, chief of surgical service, Chicago Municipal Tuberculosis Sanitarium, on "The Differential Diagnosis and Management of Solitary Circumscribed Lesions of the Lung."

Society News.—At a meeting of the Winnebago County Medical Society at the Rockford Country Club, October 13, Dr. Leon Unger, associate professor of medicine, Northwestern University Medical School, spoke on "Food Allergies." The county medical society was the guest of the Barber-Coleman Company at luncheon, October 16, following a tour of the textile division.

GENERAL

Mass Innoculation with Gamma Globulin.—Shelby County was the third in Illinois to institute mass administration of gamma globulin to its children, according to a report from the Illinois Department of Public Health. On October 14, an estimated 6,000 children through the age of fourteen years were to receive the serum at seven centers in the county. At the time the decision was made to select Shelby County twenty-one cases of polio had been reported with a projected incidence of 116 cases per 100,000 population. Of the county's twenty-one cases, sixteen children were under fifteen years of age. A majority of the cases were of the paralytic type of polio. Two deaths had been reported. The Shelby County Medical Society and the Shelby County Health Department cooperated in the mass immunization with the cooperation of community agencies. In Macon county, the first in the state to administer this mass innoculation, it was not possible to innoculate children over nine years of age, because gamma globulin was somewhat scarcer in July than it was in October. Woodford County was the second county selected for this program. Some 4,700 innoculations were administered to children under fifteen on September 12.

Chicago Physician Heads Academy of Otolaryngology.—Dr. Walter H. Theobald, Chicago, present president-elect of the American Academy of Ophthalmology and Otolaryngology, was named by special action of its council voting by mail, president to succeed Dr. John J. Shea, of Memphis, who died a few weeks after his election as president last year. Dr. Theobald will take office as president next January. Another Chicago physician, Dr. Daniel Snydacker, was made secretary, for home study courses of the Academy.

Postgraduate Conferences.—A series of postgraduate conferences have been arranged under the auspices of the Postgraduate Education Committee of the Illinois State Medical Society, of which Dr. George A. Hellmuth is chairman. On October 14, with the Saline County Medical Society acting as host, the speakers were Dr. John F. O'Brien on Basic Physiology and Electrocardiography; Dr. Robert E. Lee discussed the Clinical Aspects and Dr. Charles S. Gilbert, Therapeutic Aspects.—At a meeting in Fairfield, November 19, with the Wayne County Medical Society acting as host, the theme of the meeting was common chest conditions: their diagnosis and treatment. Speakers were Drs. Robert T. Fox, Gordon L. Snider and William M. Lees.

—The Whiteside County Medical Society acted as host to the conference in Sterling, October 22, which was held in cooperation with the faculty of Northwestern University Medical School. Speakers at this conference were Drs. Arthur E. Mahle, James B. Hurd, Samuel J. Fogelson. Three panels on the Jaundiced Patient, the Thyroid Patient, and Office and Home Treatment composed the meeting.—On October 29, in cooperation with the University of Chicago School of Medicine, a conference was held in Jacksonville with the Morgan County Medical Society as host. The following program was presented: Dr. Richard J. Jones, "The Treatment of Heart Failure"; Dr. James M. Goldinger, "Emergency Complications of Diabetes"; Dr. Dwight E. Clark, "The Surgical Treatment of Peptic Ulcer"; and "The Role of Radioiodine in Diseases of the Thyroid"; Dr. M. Edward Davis, "The Management of the Placental Stage of Labor and Postpartum Hemorrhage"; Dr. Peter V. Moulder, "The Early

Treatment of Thoracic Emergencies"; Dr. Wright Adams, "The Doctor's Nemesis-Coronary Disease"; Drs. Davis, Goldinger, and Jones participated in a panel discussion on "Medical Complications of Pregnancy."—On November 12, in cooperation with the staff of Michael Reese Hospital, a conference was held in Benton, with the Franklin County Medical Society acting as host. Speakers at this conference were Drs. Albert J. Miller, Edward A. Newman, David H. Wagner, Milton H. Dresner, and Rachmiel Levine, who participated in panel discussions on: "Complications of Myocardial Infarction", "Peptic Ulcer-Medical and Surgical Management", "Management of Thyroid Disease", and "Hemorrhage in Pregnancy and Labor." Dr. Levine, the evening speaker, spoke on "ACTH and Cortisone Therapy."—The Alexander County Medical Society acted as host to the conference in Cairo, November 18, which was held in cooperation with the staff of Passavant Memorial Hospital. Speakers at this conference were Drs. Knowlton E. Barber, Harley E. Cluxton, Jr., Fred W. Fitz, Edmund A. Gorvett, and Howard A. Lindberg, who participated in panel discussions on: "Pediatric Problems," "Challenges in Management," and "The Newer Ideas in Treatment." In the evening, Dr. Fitz spoke on "The Doctor and His Coronary Occlusion."

On November 19, in cooperation with the faculty of the Stritch School of Medicine of Loyola University, a conference was held in Kankakee with the Kankakee County Medical Society acting as host. Speakers included: Harry A. Oberhelman, M.D., George F. O'Brien, M.D., Robert F. Dillon, M.D., Peter J. Talso, M.D., John B. Hoesley, M.D., John L. Keeley, M.D., John B. Condon, M.D., Anthony C. Guzauskas, M.D., James A. Rooney, M.D., Robert J. Hawkins, M.D., Walter F. Dillon, M.D., Chester J. Gajewski, M.D., and John H. Isaacs, M.D., who participated in panel discussions on: "Treatment of Congestive Heart Failure," "Malignancy of the Colon," and "Obstetrical Emergencies." In the evening Dr. Oberhelman spoke on "What Laymen Should Know About Breast Tumors," and Dr. Edwin S. Hamilton discussed medical organization. The evening chairman was Dr. Ernest S. Klein.
of Kankakee.

"Your Doctor Speaks" over FM Station WFJL.—Since the last issue of the *Illinois Medical Journal,* the following physicians have appeared in transcribed broadcasts in a series "Your Doctor Speaks" over FM Station WFIL:

Emerson K. McVey, member of the staff, Roseland Community Hospital, October 22, The Child's Foot—Fads and Facts.

Robert B. Lewy, clinical assistant professor of otolaryngology, University of Illinois College of Medicine, October 29, Your Voice and Your Larynx.

William M. Lees, chief of surgery, Municipal Tuberculosis Sanitarium, November 5, Pulmonary Tuberculosis—What a Problem.

John D. Singer, associate attending physician, medical department, Cook County Hospital, November 12, Modern Conception of Arthritis.

Franklin A. Kyser, assistant professor of medicine, Northwestern University Medical School, November 19, Your Heart—Treat it with Care.

"Your Doctor Speaks" is presented under the auspices of the **Educational Committee** of the **Illinois State Medical Society** in cooperation with **FM Station WFJL.**

Lectures Arranged Through the **Educational Committee** of the **Illinois State Medical Society:**

Groves B. Smith, Godfrey, Okawville Woman's Club in Okawville, November 12, on Mental Health is a Community Problem.

Sanford A. Franzblau, Catholic Woman's League, November 14, on Adding Years to Your Life.

Edward K. Isaacson, Skokie, West Ridge O.R.T. in Chicago, November 17, on Child Behavior.

Carl H. Hamann, Rockford, Private Duty Nurses Group in Sterling, November 24, on Mental Hygiene Tips in Nursing.

M. R. Crew, Decatur, Adult Homemaking Class, Beason Community High School, Beason, November 30, on Problems of Parenthood.

Sanford A. Franzblau, Chicago Woman's Club, January 6, Adding Years to Your Life.

Craig D. Butler, Oak Park, Scott School PTA, January 19, on Rheumatic Fever.

C. Elliott Bell, Decatur, Joint meeting of the Woman's Auxiliary to the Logan County Medical Society and the Lincoln Woman's Club, in Lincoln, January 20, on Diet for Fat and Thin, Young and Old.

Peter J. Cotsirilos, Cicero, Daniel J. Corkery PTA, January 21, on Inter-Relation of Mental and Physical Health in Children.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Walter C. Bornemeier, Chicago, North Central Illinois Medical Association in Spring Valley, November 5, on Medical Care Plans for the Future.

Kilian F. Fritsch, East St. Louis, Marion County Medical Society in Centralia, November 19, on Backache as Applied to General Practice.

Ford K. Hick, Chicago, Macon County Medical Society in Decatur, November 24, on Use of Slow-Acting Insulins.

James E. Segraves, Chicago, Bureau County Medical Society in Princeton, December 8, on Three Common Fractures.

Ben Lichtenstein, Chicago, Stock Yards Branch of the Chicago Medical Society, December 17, on Management of Epilepsy in Children.

Edwin N. Irons, Chicago, Bureau County Medical Society in Spring Valley, January 12, on Viral Diseases: Diagnosis and Treatment.

Benjamin Pearlman, Chicago, Henry County Medical Society in Geneseo, January 13, on Clinical Significance, Diagnosis and Treatment of the Common Cardiac Arrhythmias.

Edward A. Piszczek, Forest Park, Whiteside-Lee County Medical Societies, in Dixon, January 21, on Preventive Medicine—1954.

Hugh A. Flack, Chicago, Stock Yards Branch, Chicago Medical Society, January 21, on Management and Differential Diagnosis of Cardiac and Pulmonary Dypsnea.

"All About Baby" over WBKB.—"All About Baby" is weekly telecast over WBKB, Channel 7. While the telecast is on Monday through Fridays, a physician appears under the auspices of the Educational Committee one day a week. Libby, McNeill and Libby's is the sponsor and Herbert Laufman Television Productions, the producer. The telecast features Ruth Crowley, R.N. Since the telecast returned to the air, September 9, the following physicians have appeared under the auspices of the Educational Committee: **Frederick L. Phillips, John J. Marino, Elfriede Horst**, Des Plaines, **Franklin J. Gorper, Woodruff Crawford**, Rockford, **Alwin C. Rambar**, Evanston, **Howard S. Traisman, Ernest Robbins Kimball**, Evanston, **Gilbert Lanoff, Alfred D. Biggs, Joseph Greengard, Vida Wentz** and **Robert Plotnick**, Skokie.

DEATHS

Albert Carl Apking, Chicago, who graduated at Bennett Medical College, Chicago, in 1912, died October 17, aged 72. He was a charter member of the staff of Garfield Park Hospital and a member of the Illinois State Medical Society.

Louis L. Beehler, Chicago, who graduated at Northwestern University Medical School in 1900, died November 7, aged 73.

Harry D. Cartmell, Greenville, who graduated at Northwestern University Medical School in 1905, died September 2, aged 73, of carcinoma of the prostate. He was a member of the Illinois State Medical Society.

Frederick A. Causey, Jacksonville, who graduated at St. Louis University School of Medicine in 1914, died November 3, in Community General Hospital, Sterling, aged 69. He had served at several state hospitals and was a member of the Illinois State Medical Society.

John F. Delph, formerly of Chicago, who graduated at Northwestern University Medical School in 1922, died November 7, in Gary, Indiana, aged 61. He was former president of the Passavant Memorial Hospital Staff and formerly head of the department of otolaryngology there, and a member of the Illinois State Medical Society.

Isadore Herman Deutsch, Oswego, who graduated at St. Louis University School of Medicine in 1925, died August 27, aged 56, of carcinoma of the lung. He was a member of the Illinois State Medical Society.

James Joseph Donahue, East St. Louis, who graduated at Washington University School of Medicine, St. Louis, in 1925, died August 10, aged 56, of coronary thrombosis. He was a member of the Illinois State Medical Society and a specialist certified by the American Board of Pediatrics.

William Edward Dyko, Chicago, who graduated at the Chicago Medical School in 1936, died September 26, aged 47, of coronary thrombosis and arteriosclerosis. He was a member of the Illinois State Medical Society.

Blanch Nettleton Epler, retired, Jacksonville, who graduated at Johns Hopkins University School of Medicine in 1899, died August 2, aged 88, of chronic pneumonitis.

Bruce E. Jackson, Chicago, who graduated at the Chicago Medical School in 1927, died October 21, aged 53. He was a member of the Illinois State Medical Society.

George B. Mathisen, Chicago, who graduated at University of Minnesota Medical School in 1901, died November 10, aged 78.

Charles M. Murrell, retired, Sherrard, who graduated at the Hospital College of Medicine, Louisville, Kentucky, in 1903, died September 28, at the Moline Public Hospital, aged 79. From 1925 until his retirement this year he practiced medicine in Sherrard. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Anna F. Novak, Chicago, retired, who graduated at Bennett Medical College, Chicago, in 1895, died August 31, aged 89, of cerebral hemorrhage and arteriosclerosis.

John P. O'Connell, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died October 20, aged 69. He was police physician and chief medical examiner of the Chicago Civil Service Commission for 42 years and a member of the Illinois State Medical Society.

Lester E. Odell, retired, Chicago, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1906, died October 13, aged 73. He was a member of the Illinois State Medical Society.

Alexander H. Phillips, Chicago, who graduated at the University of Illinois College of Medicine in 1914, died October 7, aged 68. He was a member of the staff of Walther Memorial Hospital and a member of the Illinois State Medical Society.

Howard Pitts, Chicago, who graduated at Bennett Medical College, Chicago, in 1911, died August 13, aged 72, of adenocarcinoma of the prostate with metastases.

William Edgar Range, Caseyville, who graduated at Barnes Medical College, St. Louis, in 1901, died August 14, aged 80, of arteriosclerotic heart disease.

Fletcher L. Strauss, retired, Chicago, who graduated at Rush Medical College in 1897, died October 20, aged 77. He was a member of the Illinois State Medical Society.

Harry W. Trigger, Peoria, who graduated at the Chicago College of Medicine and Surgery in 1913, died October 10, aged 69. He was senior staff physician at Peoria State Hospital and a member of the Illinois Medical Society.

Henry S. Zimmerman, Cameron, who graduated at Northwestern University Medical School in 1896, died November 7, aged 82. He was on the staffs of Cottage and St. Mary's Hospitals at Galesburg and of Monmouth Hospital at Monmouth. He was a member of the Illinois State Medical Society.

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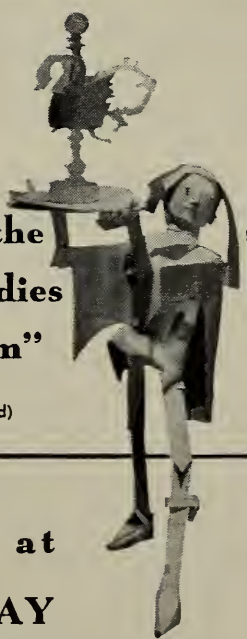
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BOOK REVIEWS



Ophthalmic Diagnosis by F. Herbert Haessler, M.D., Professor and Director of the Division of Ophthalmology, Marquette University School of Medicine. The Williams & Wilkins Company, Baltimore. 1953. $8.00

This text is a departure from the conventional book concerning ophthalmology. It was planned to function as a road map of diagnosis and not as an exhaustive account of all the recorded manifestations of disease. The author has stressed fundamental principles even in the illustrations which are diagrams rather than the usual drawings and photographs.

It does seem that the "Contents" might be more informative through better arrangement. And the "Index" seems to lack cohesion and coherence for instance "Retinopathies" appears as the title of a subsection on page 353, yet the word is not in the "Index". Another example is "Perivasculitis" (page 359) which likewise is not indexed. A few pages later (page 369) a discussion of Coat's disease occupies over a page, but the only mention in the "Index" appears under "Coates external retinopathy" on page 144 where a six line paragraph on the subject appears. Coats is the usual spelling.

The author states that it was his purpose to select from the literature those ophthalmologic data that are necessary for diagnosis and to present them in an arrangement that makes them useful for the recognition of the nature of ophthalmic disease. This he has done.

Copying and Reduplicating Medical Subjects and Radiographs. H. Lou Gibson, American Lecture Series, Charles C. Thomas, Publishers.

This volume should be in the library of anyone interested in copying or duplicating. As the author aptly states in the preface "This book is designed as an instruction treatise for the relative beginner and a handy summarization for the advanced worker."

The contents of the book covers the field well. With but little technical knowledge the photographer should be able to make good copies by following the precautions and steps carefully outlined.

J. H. U.

Practical X-ray Treatment. Arthur W. Erskine, M.D., Fourth Edition. Bruce Publishing Company, 2642 University Avenue, St. Paul, Minnesota.

This is the fourth edition of the compendium of the principles underlying the practice of therapeutic Roentgenology as well as the technics which the author used in his practice.

He devotes about one half of the book to the

(*Continued on page* 46)

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*Yow, E. M.: *Am. Pract.*, 4:521 (Aug.) 1953.

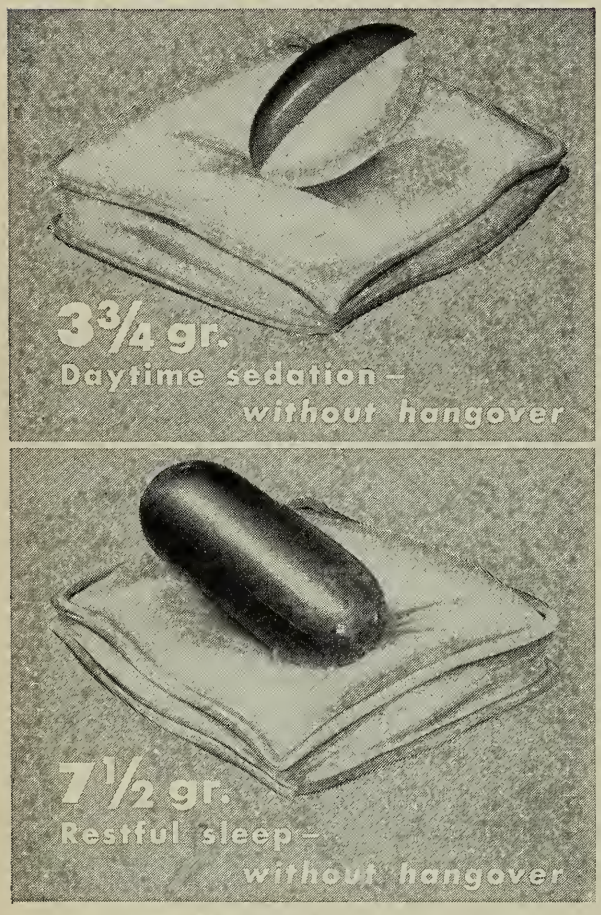
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BOOK REVIEWS (Continued)

physical principles, establishment of standard technics, and effects of x-rays on tissue.

The last half of the book is devoted to a recitation of the technics which he found useful. This portion is divided into skin Diseases, infections and inflammations, non-malignant conditions, the cancer problem and the radiologist and malignant conditions.

A bibliography and index are appended.

J. H. U.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

RESPIRATORY DISEASES AND ALLERGY: A New Method of Approach: By Josef S. Smul, M.D., Author of "Digestive Diseases and Food Allergy". Fellow, National Gastro-Ent., Assoc; Member, N. Y. Academy of Sciences. New York, Medical Library Company, 1953. Price $2.75.

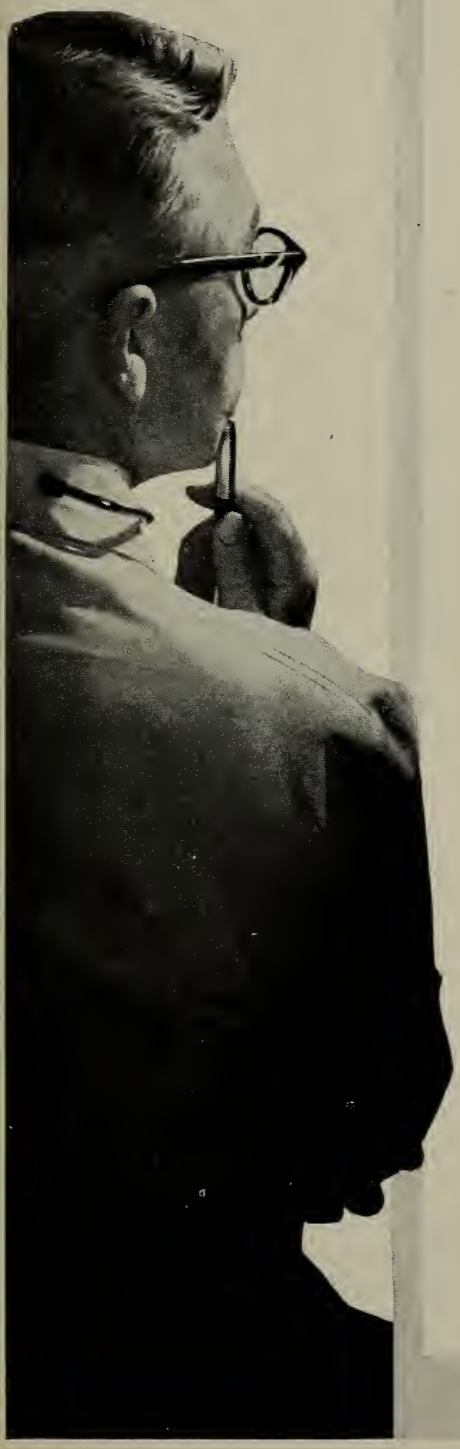
FILMS IN PSYCHIATRY, PSYCHOLOGY AND MENTAL HEALTH: Adolf Nichtenhauser, M.D., Marie L. Coleman, David S. Ruhe, M.D., Medical Audio-Visual Institute of the Association of American Medical Colleges; Published by Health Education Council, New York. 1953. Price $6.00.

A PRIMER OF CARDIOLOGY: By George E. Burch, M.D., F.A.C.P., Henderson Professor of Medicine, Tulane University School of Medicine; Physician-in-Chief, Charity Hospital, New Orleans. Second Edition, Thoroughly Revised, with 214 Illustrations. Lea and Febiger, Philadelphia, 1953. Price $5.50.

SPATIAL VECTORCARDIOGRAPHY: By George E. Burch, M.D., F.A.C.P., Henderson Professor of Medicine, Tulane University School of Medicine; Physician-in-Chief, Tulane Unit, Charity Hospital of Louisiana at New Orleans; J. A. Abildskov, M.D., Instructor in Medicine, Tulane University School of Medicine; and James A. Cronvich, M.S., With 121 illustrations. Lea and Febiger, Philadelphia, 1953.

DISEASES OF WOMEN: By Robert James Crossen, A.B., M.D., F.A.C.S., Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine; Section Head of Unit I Obstetrics and Gynecology, St. Louis City Hospital; etc., Tenth Edition, with Nine Hundred and Ninety Illustrations Including Forty-one in Color. St. Louis, The C. V. Mosby Company, 1953. Price $18.50.

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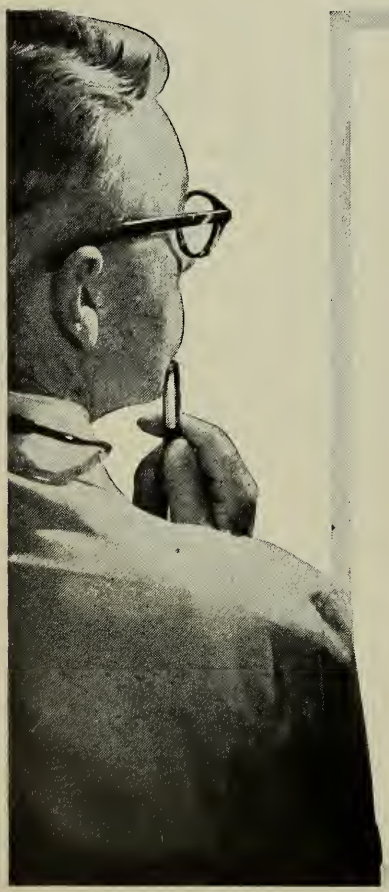
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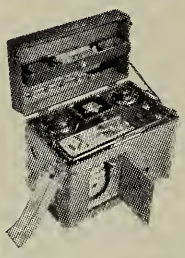


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Recognition of pain or discomfort, be it physical or mental, is a prerequisite if normal recovery is to be expected. The greater the neurotic element in a physical complaint, the greater the need for the substitution of a positive, psychic mechanism which motivates recovery. The denial of the existence of the complaint causes it to grow in size as it is driven deeper into the swirling whirlpools of the patient's mind. Its acceptance, its examination, its discussion, in short, its being "aired," increases its amenability to both physical therapy and psychotherapy by bringing it closer to the surface of the open waters of the reasoning brain. The virus of resentment is anaerobic. The germ which motivates recovery is aerobic. The psychiatrist chose a happy word when he first spoke of "ventilation." *Christopher Leggo, M.D., Resentment — An Obstacle to Recovery. Indus. Med. and Surg. June* 1953.

SENILE DEMENTIA

More and more of our older patients are being treated at home and in general hospitals. The diagnosis of senile dementia should not be, and no longer is a one-way ticket to the nearest state hospital. Undue pessimism has now given way to optimistic investigation and help. Many of these cases have proved not to be incurable at all and have, after treatment, returned to the community to enjoy their admittedly lessened resources to the fullest. *Albert J. Silverman, M. D., Sme Recent Contributions In The Field Of Geriatric Psychiatry. Am. J. M. Sc., Jan. 1953.*

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*Shaw, H.N.; Henriksen, E.; Kessel, J.F.; and Thompson, C.F.: Clinical and Laboratory Evaluation of "Vagisol" in the Treatment of Trichomonas Vaginalis Vaginitis, Western J. of Surg., Obst. & Gynec. 60:563 (Nov.) 1952.

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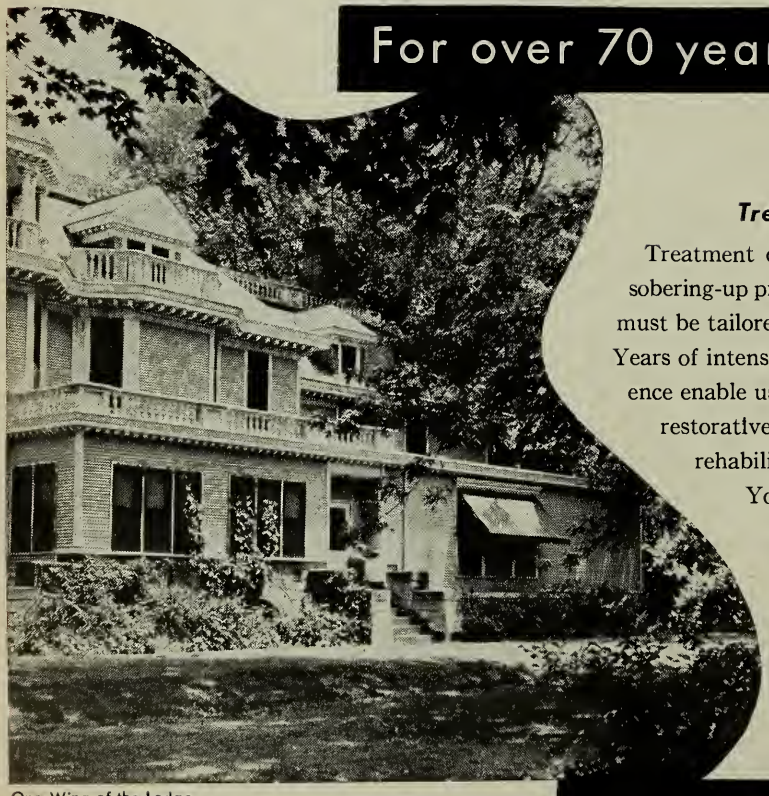
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NEW ALLERGIES TO NEW ANTIBIOTICS

The newer antibiotics have created a new problem in allergy which must be faced by every practitioner of medicine. Topical applications of penicillin and some other antibiotics to the skin have been largely abandoned because of their tendency to produce contact sensitization. The delayed type of reaction from penicillin, occurring customarily about ten days after its administration, and consisting mainly of urticaria, angioneurotic edema, arthralgia and fever, still affects 2 to 5 per cent of those receiving the drug. The use of different types of penicillin or the concomitant use of antihistamines has had no appreciable effect on this tendency. More recently it has become apparent that a more dangerous type of penicillin allergy is on the increase. Due to repeated use of the drug, an increasing number of people are acquiring the anaphylactic type of sensitivity. In mild form this may consist of symptoms of urticaria or asthma immediately following administration of the drug. In its more severe form the patient goes into shock and frequently becomes unconscious. In such instances a fatal outcome is not unlikely. There is good reason to believe that the fatalities from such anaphylactic episodes now amount to several score. Such reactions presumably may result from any type of penicillin, and recently it has come to light that the iodide salt of penicillin, penethamate hydriodide (neo-penil[R]) is particularly likely to produce such effects. *Samuel M. Feinberg, M.D. The Role Of The Non-Specialist In The Care Of Allergic Disease. Arizona Med. J. of Arizona Med. Assoc. October* 1953.

THE NEW LOOK

The second half of this century is indeed becoming the age of geriatrics. Once hustled into a state mental institution, the eldery person who develops mental symptoms is now being given a second look. *Albert J. Silverman, M.D., Some Recent Contributions In The Field Of Geriatric Psychiatry. Am. J. M. Sc., Jan. 1953.*



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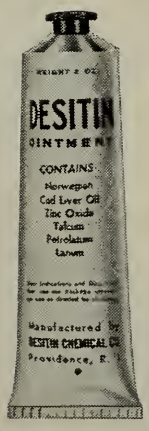
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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgergy. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.



UNTOWARD REACTIONS

Untoward reactions develop with the use of the antibiotics. These toxic reactions and idiosyncrasies present new and additional problems in the control of surgical infections. Pruritus, stomatitis, allergic skin reactions, and the Herxheimer type of febrile reaction have been noted with all the antibiotic drugs. Aplastic anemia has developed after the use of some of these. Gastrointestinal symptoms are likely to develop with aureomycin and terramycin, and are quite discomforting to the patient. Bacitracin, neomycin and polymyxin produce a definite threat of nephrotoxicity. Deaths attributed to penicillin have usually been due to exfoliative dermatitis, Jarisch-Herxheimer reactions, and anaphylaxis. Nonthrombocytopenic purpura and nephritis with the nephrotic syndrome as manifestations of penicillin sensitivity have been reported. The streptomycin deaths were due to toxic encephalopathy and dermatitis with stomatitis. Asthma, angioneurotic edema, hypotension and shock-like states are attributed to the antibiotics. Flaxman states that the antibiotics have caused the largest number of deaths among those due to parenteral medications. The more these drugs are used, the longer the list of untoward reactions will become.—*Edward B. Mersch, M.D., Wound Healing and the Antibiotics. J. Ky. State M.A., September,* 1953

HOSPITAL PHYSICIAN TROUBLE

This potential conflict between the hospital (which has an increasing responsibility for the care of the patient and the health of the community) and the physician (with his personal responsibilities to the patient) has frequently broken out in an epidemic of resolutions and counter-resolutions that have been adopted and readopted by hospital and medical associations during the past 20 years. Much emotion, heat and adrenalin have been generated by these resolutions and the controversies arising from them have served only to aggravate misunderstandings and to disturb the public confidence in hospitals and in the medical profession. The realization that nothing constructive was being accomplished has stimulated physicians, hospital administrators and trustees to get together to re-evaluate the problem and to try to reach some common agreement. *Albert W. Snoke, M.D. A Step Forward In Hospital-Physician Relationships. Hospitals. October* 1953.

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ARMY EMPHASIZES "DOCTOR-PATIENT" RELATIONSHIP

Instruction in interpersonal relationships in the care and management of patients will be emphasied in all Army Medical Service training programs, it has been announced by Maj. Gen. George E. Armstrong, Surgeon General of the Army.

More often referred to as the "doctor-patient relationship", the scope of the concept within the Army Medical Service's concept of the prop- to include all members of the medical team handling patients.

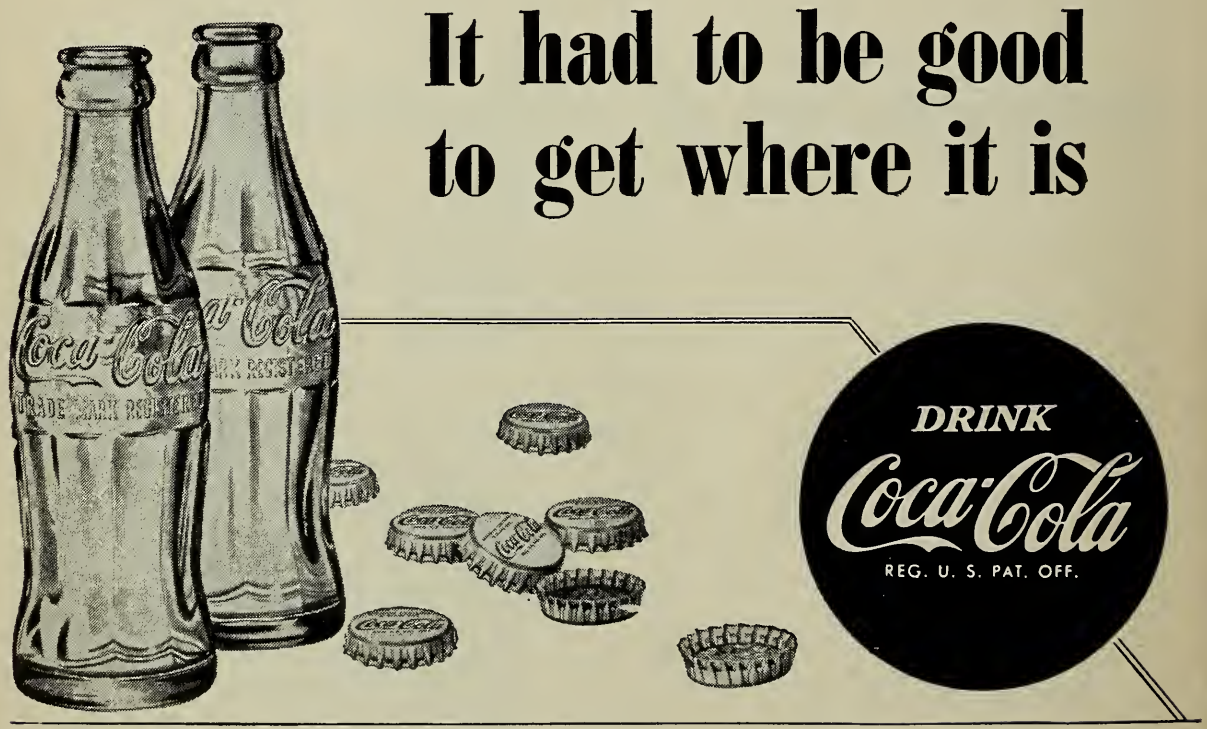
"Courtesy, consideration and sympathetic approach" have become the key words describing the Army Medical Service's concept of the proper relationship between the medical team and the patient on all levels.

So important does the Army Medical Service consider the interpersonal relationships between medical teams in treatment facilities and the patients commited to their care that General Armstrong recently called together a panel to discuss means of overcoming problems incident to interpersonal relationships.

The panel recommended that "Specifically, in all courses taught in our hospitals, the Army Medical Service Graduate School, the Medical Field Service School and the Medical Replacement Training Center there will be included additional instructional hours on the principles and practice of interpersonal relationships. Constant emphasis will be placed on the subject. Thus, the idea will be stressed at all levels of training.

"In addition, the concept will be kept alive in all medical installations dealing with patients by constant reiteration. This will consist of broad policy letters, conferences, recurrent instruction, articles in bulletins and publications and by personal contacts. It is planned to reconsider the subject at stated intervals in meetings with personnel, both professional and nonprofessional."

The panel appointed by General Armstrong was composed of Col. Clifford V. Morgan, Inspector General, Office of The Surgeon General; Brig. Gen. Rawley E. Chambers, Chief of the Professional Division, Office of The Surgeon General; Col. Paul Hayes, Chief Medical Con-



sultant, Office of The Surgeon General; Col. Ruby F. Bryant, Chief of the Army Nurse Corps; Col. Clement F. St. John, Chief of the Medical Plans and Operations Division, Office of The Surgeon General; and Col. Robert L. Black, Chief of the Medical Service Corps.

Col. Charles L. Leedham, Chief of the Education and Training Division, Office of The Surgeon General, presented the opening remarks to the panel and acted as moderator.

In addition to the actual panel members the following officers were present during the proceedings: Maj. Gen. Silas B. Hays, Deputy Surgeon General; Brig. Gen. Elbert DeCoursey, Director of the Armed Forces Institute of Pathology; Brig. Gen. Stanhope Bayne-Jones, MC (USAR), Technical Director of Research, Medical Research and Development Board; Col. John R. Wood, Chairman of the Medical Research and Development Board; Col. Joseph R. Sheaffer, Chief Surgical Consultant, Office of The Surgeon General; and Col. C. T. Budge, Chief of the Dental Standards Branch, Dental Division, Office of The Surgeon General.

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THE IMPACT OF A STROKE

The emotional impact of a stroke is overwhelming to the patient and—we believe—equally to those with whom he associates. For that reason, we feel that the management includes not only the individual afflicted but his family as well. There are certain suggestions regarding the attitude of the family which can assist immeasurably in the restoration of the patient. We have found that it is wise to forewarn them of possible untoward reactions to be expected: the desire to be alone, incessant weeping for any reason, self-pity, an unreasonable perversity, and even unfounded suspicion, to say nothing of a definite feeling of resentment prompted by the dependency (insecurity) that now appears to be the patient's lot. These character (personality) changes can be counteracted by the family's matter-of-fact acceptance of the aftermath of the stroke. Vocal expressions of sympathy tend to increase the feeling of self-pity; a direct and casual attitude in establishing exercises and rehabilitation schedules can offset the despair of helplessness and despondency that has been or could be engendered.

We have found that the sooner a reasonably normal schedule is established, the sooner will the sense of independence be inculcated. *Murray B. Ferderber, M.D., Rehabilitation After A Stroke. Pennsylvania Med. J. Sept.* 1953.

EMOTIONAL FACTORS IN AGED

Organic disease in the brain, although important, is no longer considered the only factor in the development of senile or arteriosclerotic psychoses. Emotional factors are now thought to play an important role. Brain damage is as frequent in nonpsychotic as in psychotic oldsters. The psychosis is regarded as the result of the interaction of organic and functional factors. Aging people are thus less likely to develop functional or "organic" mental illness if they have healthy personalities, feel secure, are wanted, and can engage in useful activity which stimulates the preservation of their personality organization. *Albert J. Silverman, M.D. Some Recent Contributions In The Field Of Geriatric Psychiatry. Am. J. M.Sc., Jan. 1953.*

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Medicines in Hospital	10.00	20.00	30.00	40.00
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THE KANSAS HEALTH PLAN

The medical school has these as its responsibilities: that it defines the needs of its state with respect to medicine, that it formulates programs to meet these needs, that it implements these programs as wisely and as rapidly as possible. I should like here to present some examples. Four years ago the State of Kansas was faced with two grave medical problems: it was losing doctors almost at the same rate as it was gaining population; its mental hospitals were in a deplorable condition. The medical school was able to help in the solution of these two problems — in the first case by spearheading a rural health program, and in the second case by volunteering to aid a program that had already achieved phenomenal success under the direction of a farsighted Board of Social Welfare composed of laymen.

The rural health program, or Kansas plan as it has been called, was thoughtfully conceived by the dean of the medical school, the state medical school, the state medical society, the state farm bureau and the state legislature. Its provisions were simple: the medical school was enlarged, small community hospitals were built and attractive offices were made available to young physicians. As a part of the program a rural health preceptorship was made a part of the school's curriculum. For periods of six to twelve weeks, each fourth year medical student was assigned to a carefully selected physician practicing in a community whose population did not exceed 2,500 persons; with this physician he lived, observed and worked.

I have recently collected the statistics of the four years that have elapsed since this program was put into effect; the program has been an undeniable success. In each of the last two years Kansas has gained a few more than one hundred doctors; further, seventy-nine physicians settled to practice in towns of 1,500 persons or less in the same period. Two trends were reversed — the shift from rural to urban medicine, and the steady loss of doctors from the state. This, I believe, was in large part due to the imaginative

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leadership of the medical school's administration.

So successful was this program that the school has recently instituted a similar preceptorship program in each of four of the state's mental institutions.

W. Clarke Wescoe, M.D., Responsibilities of the Medical School to the State it Serves. Mo. Med., Nov., 1953.

THE STUTTERER

It is a truism that the stutterer is his own worst enemy and must change his personality if he hopes to overcome his speech disorder.

Destructive emotions are the dynamic forces that keep the stutterer's symptoms active. If we delve beneath the surface of the stuttering patient, we find a great deal of anxiety; and beneath the anxiety we usually find resentment against parents and people in general, intolerance of the shortcomings of others, jealousy of their good fortune, bitterness, egocentricity and selfishness.

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THE STUTTERER (Continued)

stutterer in two ways. First, they produce actual physiologic changes within him. Secondly, through the mechanism of projection, they have profound psychologic effects upon him. Since the stutterer has no way of judging others except by his own feelings, he "projects" these feelings upon the world at large. He invests it with his own hostility and constantly feels in danger of incurring its wrath. Everyone becomes a potential enemy lying in wait to take advantage of his least sign of weakness. This explains why the stutterer can talk without difficulty when he is alone but begins to have trouble as soon as someone else—the "enemy"—approaches. *Talk, August-September,* 1953.

PUBLIC RELATIONS AND SCHOOLS

Put your house in order. The requisites of good public relations (for medical schools) are high standards of operation, quality instruction and research, and a sincere desire to serve the public. There is a great truth in the statement that "public relations begins at home."

In selling the institution to the public, the school itself is the product. Every dean knows the futility of trying to sell inferior instruction. The problem cannot be solved by hiring a first-class press agent who can interpret only what he sees. No amount of publicity will improve the institution's public relations if, basically, it is not operating in the interest of the public. On the other hand, if the medical school pursues a clean professional and business life, if it is fair and honest in trying to give its faculty and staff, its students and alumni, and the general public a fair break, then good public relations becomes a very distinct possibility. *C. Lincoln Williston. The Medical School And Public Relations. J. Med. Education. May* 1953.

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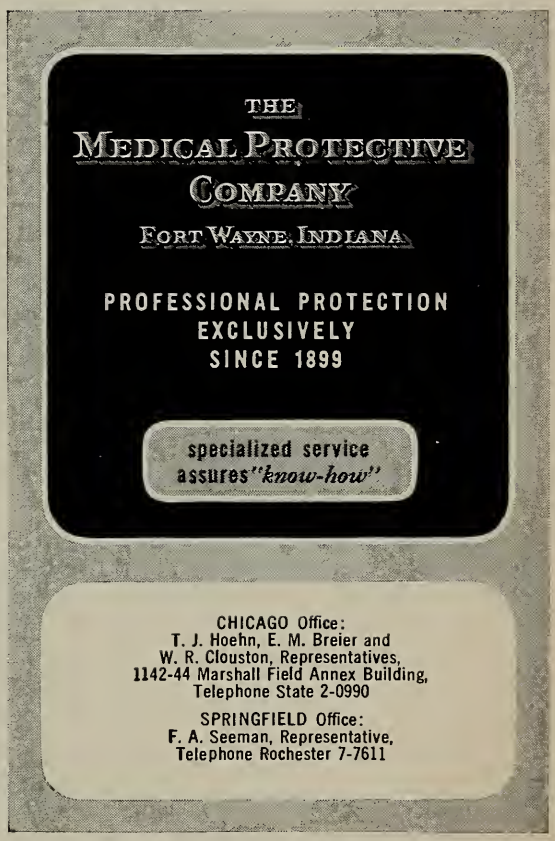
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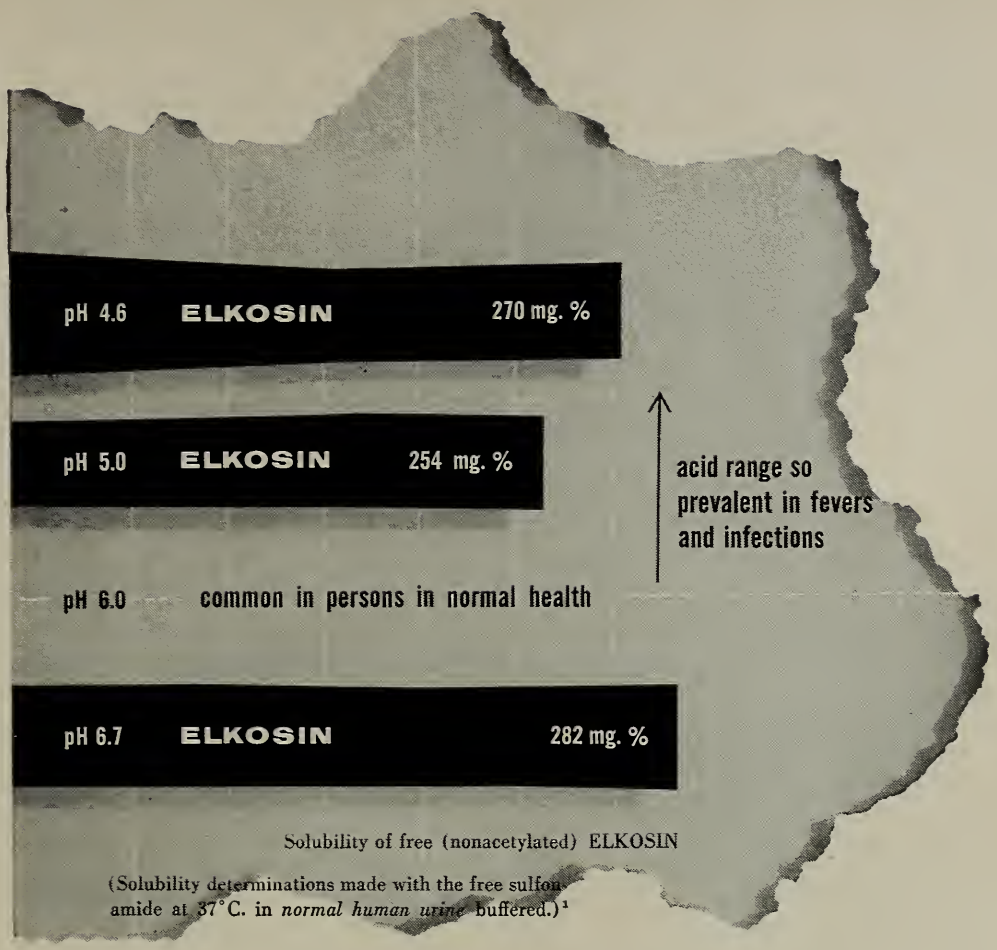
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